

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The State of Kansas requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Serious Emotional Disturbance (SED) Waiver

C. Waiver Number: KS.0320

Original Base Waiver Number: KS.0320.

D. Amendment Number: KS.0320.R04.05

E. Proposed Effective Date: (mm/dd/yy)

07/01/21

Approved Effective Date of Waiver being Amended: 04/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The Kansas State Legislature approved an increase to the Protected Income Level to 300% of Supplemental Security Income. This amendment is to allow for waiver participants to gain access to the new Protected Income Level. The state sees no adverse effects to waiver participants.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration	

Component of the Approved Waiver	Subsection(s)
and Operation	
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Kansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Serious Emotional Disturbance (SED) Waiver

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

Original Base Waiver Number: KS.0320

Waiver Number: KS.0320.R04.05

Draft ID: KS.009.04.06

D. Type of Waiver (*select only one*):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/17

Approved Effective Date of Waiver being Amended: 04/01/17

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

KanCare 1115 Demonstration Project

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**2. Brief Waiver Description**

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Serious Emotional Disturbance (SED) Waiver is designed as a hospitalization diversion program. The goal of the SED waiver is to divert psychiatric hospitalization through the provision of intensive home and community based support services in an effort to maintain children and youth in their homes and communities.

The Kansas SED waiver provides six services to participants and their families that are not available to other Medicaid youth. These services are: wraparound facilitation, short term respite care, attendant care, independent living/skills building, parent support and training, and professional resource family care. Participants eligible for the waiver are between the ages of 4 and 18. An age exception for clinical eligibility may be requested for participants under the age of 4 and over the age of 18 through age 21 who are experiencing a serious emotional disturbance and are at risk for inpatient psychiatric hospitalization. Foster care children/youth on the SED waiver will not be able to access short term respite care or professional resource family care. The foster care contractor is able to arrange for children/youth access to these two services through their contract with the state.

Both clinical and financial criteria must be met to be eligible for the waiver. The clinical assessment is a multi-step process. A participant must have a mental health diagnosis determined by a Qualified Mental Health Professional (QMHP) and qualifying scores on two standardized assessment tools. These tools are the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Behavior Checklist (CBCL). Financial eligibility is determined by the Kansas Department of Health and Environment (KDHE). In addition, a statistically significant sample (95/5) of the assessments will be done in coordination with a third-party contractor. The third-party contractor will meet the requirements of a QMHP. The contractor will complete their own CAFAS assessment during the CMHC assessment of the child. The two CAFAS will be scored independently.

The SED waiver is managed by the Operating Agency, the Kansas Department for Aging and Disability Services. SED Waiver services are provided by 25 Community Mental Health Centers (CMHCs) and two affiliated organizations.

Each waiver participant will have a plan of care (POC). The POC is developed by the Managed Care Organization (MCO) and will describe waiver services the child is to receive, their frequency, and the type of provider who is to furnish each service. All waiver services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval by the selected KanCare MCO. Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the child's written plan of care.

Programmatic oversight and control of the waiver is provided by Kansas Department for Aging and Disability Services (KDADS). KDADS has taken the necessary safeguards to protect the health and welfare of children receiving services under this waiver. This is accomplished by setting adequate standards for all providers that furnish HCBS/SED waiver services and ensuring those standards are met prior to furnishing waiver services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. Participant Rights. **Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

A public notice was not required as this is not a substantive change. The Tribal Notice was posted June 10, 2021 and ended June 24, 2021. The Tribal Notice did not elicit any comments.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Graff-Hendrixson

First Name:

Bobbie

Title:

Senior Manager, Contracts, SPAs, Regulations, and Fiscal Agent Operations

Agency:

Kansas Department of Health and Environment.

Address:

900 SW Jackson, Room 900 N

Address 2:

City:

Topeka

State:

Kansas

Zip:

66612-1220

Phone:

(785) 296-0149

Ext:

TTY

Fax:

(785) 296-4813

E-mail:

Bobbie.Graff-Hendrixson@ks.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Philbern

First Name:

Sam

Title:

SED Waiver Program Manager

Agency:

Kansas Department for Aging and Disability Services Community Supports and Services

Address:

503 S Kansas Ave

Address 2:**City:**

Topeka

State:

Kansas

Zip:

66603

Phone:

(785) 296-6843

Ext:

TTY

Fax:

(785) 296-0256

E-mail:

samuel.philbern@ks.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

Kurt Weiter

State Medicaid Director or Designee

Submission Date:

Jun 25, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

weiter

First Name:

kurt

Title:

	<div>Waiver Program Manager</div>		
Agency:	<div>KDHE</div>		
Address:	<div>900 SW Jackson Avenue, Suite 900 N</div>		
Address 2:	<div></div>		
City:	<div>Topeka</div>		
State:	<div>Kansas</div>		
Zip:	<div>66612</div>		
Phone:	<div>(785) 296-8623</div>	Ext: <div></div>	TTY
Fax:	<div>(785) 296-4813</div>		
E-mail:	<div></div>		
Attachments	<div>Kurt.Weiter@ks.gov</div>		

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

There will be no negative impact for waiver enrollees.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this

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waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

Kansas Department for Aging and Disability Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations, State Plan Amendments (SPAs) and Medicaid Management Information System (MMIS) policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.) The state leadership-level meetings occur weekly and additional meetings occur as needed.

In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:

- a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
 - Information received from CMS;
 - Proposed policy changes;
 - Waiver amendments and changes;
 - Data collected through the quality review process
 - Eligibility, numbers of providers being served
 - Fiscal projections; and
 - Any other topics related to the waivers and Medicaid.
- b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.
- c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.
- d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. KDHE has oversight of all portions of the program and the KanCare MCO contracts, and does collaborate with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration has been through the long term care meetings, KanCare Steering meetings, joint policy meetings, are all important parts of the overall state's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are part of the state's KanCare comprehensive Medicaid managed care program. The quality monitoring and oversight for the program, and the interagency monitoring (including the SSMA's monitoring of delegated functions to the Operating Agency) is guided by the joint long term care (LTC) meetings. A critical component of that strategy is the engagement of the LTC stakeholders, which brings together leadership, program management, contract management, fiscal management and other staff/resources to

collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including LTC meetings – is on a quarterly basis. Continuous monitoring is being conducted, including on monthly and other intervals, the aggregation, analysis and trending processes will be built around that quarterly structure.

The interagency agreement between KDHE and KDADS is an evergreen agreement. This agreement is reviewed on a yearly basis by both agencies to determine if edits and changes are needed and is currently under revision.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The State's Community Mental Health Centers (CMHC) conduct participant waiver assessment and level of care evaluation activities for current and potential consumers, as well as options counseling. The CMHC will work with a third party contractor to administer CAFAS assessments alongside the CMHC's. The contractor will be responsible for being present during a statistically significant sample of new clinical eligibility assessments. The contractor will sit in during the evaluation conducted by the CMHC and fill out their own CAFAS during this time. The CMHC and contractor will score the assessments independently of each other to ensure the CAFAS is administered correctly, found to be valid, and that the client meets SED functional eligibility criteria.

The state's contracted Managed Care Organizations (MCO) are responsible for ensuring paid support staff or other professionals carry out the plan of care that supports the child's functional development and inclusion in the community. The state's contracted MCOs conduct plan of care development and related service authorizations, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program including this waiver.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency

(when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

The State's Community Mental Health Centers (CMHC) conduct participant waiver assessment and level of care evaluation activities for current and potential consumers, as well as options counseling. The CMHC will work with a third party contractor to administer CAFAS assessments alongside the CMHC's. The contractor will be responsible for being present during a statistically significant sample of new clinical eligibility assessments. The contractor will sit in during the evaluation conducted by the CMHC and fill out their own CAFAS during this time. The CMHC and contractor will score the assessments independently of each other to ensure the CAFAS is administered correctly, found to be valid, and that the client meets SED functional eligibility criteria.

The CMHC is also responsible for providing services to the clients found eligible for the SED waiver. The CMHC will follow the plan of care developed by the MCO.

The state's contracted Managed Care Organizations (MCOs) are responsible for ensuring paid support staff or other professionals carry out the plan of care that supports the child's functional development and inclusion in the community. The state's contracted MCOs conduct plan of care development and related service authorizations, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manuals, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program including this waiver.

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Kansas Department for Aging and Disability Services/ Community Services and Programs Commission

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Contracted entities, including both contracted entities/providers and the state's KanCare managed care organizations, are monitored through the State's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS. All functions delegated to contracted entities are included in the State's comprehensive quality strategy review processes. A key component of that monitoring and review process will be the interagency monitoring team, which will include HCBS waiver management staff from KDADS. In addition, the SSMA and the State operating agency continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement includes oversight and monitoring of all HCBS programs, the KanCare MCOs and independent assessment contractors.

The KanCare Quality Improvement Strategy and interagency agreements/monitoring teams ensure that the entities contracting with KDADS (the Waiver Operating Agency) are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1115 waiver, Kansas statutes and regulations, and related policies. Included in the QIS is an ongoing assessment of the results of onsite monitoring and in-person reviews with a sample of HCBS waiver participants. The interagency monitoring team meets quarterly. This monitoring team reviews quarterly quality reports submitted from KDADS to KDHE on the waiver performance measures. KDADS and KDHE determines if contract parameters are met based upon performance measure outcomes and required outcomes provided in the MCO and CMHC contracts.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment				
Waiver enrollment managed against approved limits				
Waiver expenditures managed against approved levels				
Level of care evaluation				
Review of Participant service plans				
Prior authorization of waiver services				
Utilization management				
Qualified provider enrollment				
Execution of Medicaid provider agreements				
Establishment of a statewide rate methodology				
Rules, policies, procedures and information development governing the waiver program				
Quality assurance and quality improvement activities				

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

06/30/2021

methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
 $N = \text{Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency}$
 $D = \text{Number of Quality Review reports}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

Quality Review Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
 $N = \text{Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports}$
 $D = \text{Number of Long-Term Care meetings}$

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

Responsible Party for data	Frequency of data	Sampling Approach <i>(check)</i>
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collection/generation (<i>check each that applies</i>):	collection/generation (<i>check each that applies</i>):	<i>each that applies</i> :
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
N = Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
D = Number of waiver policy changes implemented by the Operating Agency

Data Source (Select one):

Other

If 'Other' is selected, specify:

Presentation of waiver policy changes

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency N =
Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D = Total number of waiver amendments and renewals

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Number of waiver amendments and renewals

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. Staff of all three MCOs engage with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. The MCOs have begun to collect data regarding the waiver performance measures and reporting options. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results are tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Collaboration Team (iACT).

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>
		HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability or Developmental Disability, or Both					
		Autism		<input type="checkbox"/>	<input type="checkbox"/>
		Developmental Disability		<input type="checkbox"/>	<input type="checkbox"/>
		Intellectual Disability		<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness					
		Mental Illness		<input type="checkbox"/>	<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Serious Emotional Disturbance	4	18	

b. Additional Criteria. The state further specifies its target group(s) as follows:

To be clinically eligible for the SED Waiver, youth must meet age requirements, meet the SED clinical criteria, have qualifying scores on standard assessments, and be at risk for inpatient psychiatric hospitalization.

Age requirements: youth between the ages of 4 and 18 may be considered for SED waiver eligibility. There are exception processes in place for youth younger than 4 and older than 18.

Minimum Age Exception: Youth under the age of 4 who meet the clinical criteria for the SED waiver may be found eligible through the minimum age exception process. The Community Mental Health Center (CMHC) may apply for an exception through the Operating Agency. The CMHC submits requests to Operating Agency for consideration of a minimum age exception. The documentation includes the completed initial clinical eligibility packet and clinical narrative from a QMHP indicating the youth's risk for inpatient psychiatric hospital level of care based upon presenting behaviors related to a qualifying mental health disorder. Receipt of the exception request is received and documented through an online Exception Database. The exception request is routed to the SED Waiver Program Manager at the Operating Agency for review. Denied exception requests are reviewed by two staff members, including a clinical reviewer and a program reviewer. Exception requests may be denied if the youth has not been determined to have serious emotional disturbance. A determination is made within three to five business days of receipt, documented in the online Exception Database, and an electronic email is sent to the CMHC.

A. Electronic copies of the Exception Database are sent by the Operating Agency to the health plans on a weekly basis for verification purposes during the SED waiver service prior authorization process. Approval of the exception request must be granted prior to the provision of waiver services.

Maximum Age Exception: Youth over the age of 18 who meet the clinical criteria for the SED Waiver may be found eligible through the maximum age exception process. The CMHC may apply for such an exception through the Operating Agency. The CMHC submits the standard forms to the Operating Agency for consideration of a maximum age exception. The documentation includes the completed initial clinical eligibility packet and a clinical narrative from a QMHP indicating the youths risk for inpatient psychiatric hospitalization based upon presenting behaviors related to a qualifying mental health disorder. In addition to the clinical narrative, the CMHC also provides an attestation that the youth has received community-based services any time during the past 6 months prior to turning age 18 or would have accessed community-based services during that time period but were unable due to their institutional or residential status. Receipt of the exception request is received and documented through an online Exception Database. The exception request is emailed to the identified staff at the Operating Agency for review. Denied exception requests are reviewed by three staff members, including a clinical reviewer and a program reviewer. Maximum age exceptions may be denied because youth did not receive community-based services any time during the past 6 months and was not prevented from accessing such services due to their institutional or residential status. Exception requests may also be denied if the youth has not been determined to have serious emotional disturbance. A determination is made within three - five business days of receipt, documented in the Exception Database and a electronic email is sent to the CMHC. The Operating Agency does send electronic copies of the Exception Database to the health plans on a weekly basis for verification purposes during the SED Waiver service prior authorization process. Approval of the exception request must be granted prior to the provision of waiver services.

Criteria for Serious Emotional Disturbance (SED): The term SED refers to a diagnosed mental health condition that substantially disrupts a youth's ability to function socially, academically, and emotionally. Youth with SED meet the following criteria: age, duration and diagnosis, and functional impairment.

Age: Youth must be under the age of 18 or under the age of 22 if granted an age exception.

Duration and Diagnosis: The youth currently has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the most current DSM. Disorders include those listed in the most current DSM or the ICD10 equivalent with the exception of DSMV "V" codes, substance abuse or dependence, and developmental disorders, unless the above disorders co-occur with a diagnosable disorder that is accepted within this definition.

Functional Impairment: The disorder must have resulted in functional impairment, which substantially interferes with or limits youth's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties (internalizing and externalizing) interfering with or limiting a youth from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional

impairments of episodic, recurrent, and continuous duration are included. Youth who would have met functional impairment criteria without the benefit of treatment or other support services are included in this definition. Examples of school disruption are in-school suspension, out-of-school suspension, or withdrawn at school to the point of performance being negatively impacted. Examples of family disruption are at-risk of out-of-home placement, physical aggression at home, or suicidal ideation. Examples of community disruption are law enforcement contact, unable or serious difficulty participating in extracurricular activities due to behavior, or isolating from peers. Functional impairment does not qualify if it is a temporary response to stressful events in the youth's environment. Functional impairment also does not qualify if it can be attributed solely to an intellectual, physical, or sensory deficit.

Standard Assessments: Youth must meet standard thresholds on two required assessment tools: the Child Behavior Checklist (CBCL) and the Child and Adolescent Functional Assessment Scale (CAFAS).

CBCL: The CBCL is a self-reporting assessment that families or caregivers complete. The following versions of the CBCL are accepted: the standard CBCL, the Youth Self Report (YSR) and the Teacher Report Form (TRF). In cases where either the Youth Self Report or the Teacher Report Form is used, the tools would be completed by the identified reporting individual. The completed tool is scored by the CMHC through an automated system to arrive at the subscale scores. The child or youth must have a qualifying score of 70 on any subscale of the Child Behavior Checklist (CBCL). For youth over the age of 18, the Adult Behavioral Check List (ABCL) may be substituted for the CBCL. The range of clinical scores on the ABCL is the same as those utilized for children under the age of 18. For youth that have a subscale score between 63-69 the CMHC may request a CBCL exception from the Operating Agency. The standard process and applicable forms are available to the CMHC as attachments to the SED Waiver Manual. The CMHC submits the standard forms to the Operating Agency for consideration of an exception to a CBCL Score. The documentation includes the completed initial clinical eligibility packet and clinical narrative from a qualified mental health professional indicating the youths risk for inpatient psychiatric hospitalization based upon presenting behaviors related to a qualifying mental health disorder. In addition to the clinical narrative, the CMHC also provides a clinical rationale as to any precipitating factors that may have resulted in the scores falling below qualifying ranges. The Operating Agency documents the receipt of the exception request through the Exception Database. The exception request is routed to the identified staff at the Operating Agency for review. Denied exception requests are reviewed by three staff members, including a clinical reviewer and a program reviewer. CBCL exceptions may be denied because no score falls within the 63-69 range. Exception requests may be denied if the youth has not been determined to have serious emotional disturbance. Also, a licensed clinician reviews the clinical narrative indicating risk of inpatient psychiatric hospitalization. A determination is made within three business days of receipt, documented in the Exception Database and a letter is sent to the CMHC. The Operating Agency will send electronic copies of the Exception Database to the health plans on a weekly basis for verification purposes during the SED Waiver service prior authorization process. Approval of the exception request must be granted prior to the provision of waiver services.

CAFAS: In addition to qualifying scores on the CBCL, a youth must also have a qualifying score on the Child and Adolescent Functional Scale (CAFAS). A qualified mental health professional trained in the use of the tool completes the CAFAS. The CAFAS is used to assess a child/youth's day-to-day functioning across critical life domains. The following domains are assessed: school/work, home, community, behavior towards others, moods and emotions, substance abuse, self-harm, and thinking. The qualifying score for the CAFAS is a total score of 100 or a score of 30 on two subscales. The qualified mental health professional documents the results of the CAFAS on the initial clinical eligibility packet. There is no exception process for the CAFAS. For children under the age of 5, the Preschool and Early Childhood Functional Assessment Scale (PECFAS) may be substituted for the CAFAS. The range of clinical scores on the PECFAS are the same as those utilized for children above the age of 5.

Risk for Inpatient Psychiatric Hospitalization: Children and youth at risk for inpatient psychiatric hospitalization, those currently admitted to a psychiatric hospital or those recently screened for admission to an inpatient psychiatric hospital but diverted to the SED waiver may be eligible. The qualified mental health professional assesses the risk for inpatient psychiatric hospitalization by completing the initial clinical eligibility packet, through a clinical narrative detailing the child or youths risk for inpatient psychiatric hospitalization, and by attestation evidenced by their signature, date and credentials on the completed initial clinical eligibility packet. The completed initial clinical eligibility packet is required to be maintained in the participant's medical record to demonstrate need for Level Of Care. Verification of this documentation is made through the regularly scheduled SED waiver chart reviews.

Any approved exceptions to age or CBCL score are documented by an approval letter from the Operating Agency. The

CMHC is required to maintain all approval notices in the participants medical record. Eligibility indicators are verified through SED waiver chart reviews.

- c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

The participant's plan of care is reviewed every 90 days or when the child's needs change, wraparound services are provided on an as needed basis, and there is an yearly review of services as long as the participant receives SED Waiver services. Throughout this process, the participant's needs, goals, objectives, resources, preferences, participant's desired outcomes, and strengths are identified. At any time, the participant, their family, or the therapist may identify a need for a change in supportive services for the participant. As the participant approaches the age of 22, a continuum of services will be identified by the participant and members of the wraparound team. The CMHC staff will link and access those identified services to the participant to achieve a successful transition. Coordination between the CMHC's programs for children/youth and CMHC's adult programs will occur to aid in the transition. When the participant is transitioning out of the SED Waiver due to maximum age the CMHC evaluates the participant for adult community based services and mental health supports. If the participant meets the applicable criteria for another waiver then transition to that program will be supported by the CMHC using the approved methods in the waiver or program that is determined to best meet the participants needs. Transition planning for a youth may begin as early as with the annual review that occurs in the year prior to turning age 22. An individual who remains clinically eligible will continue to receive services until his/her 22nd birthday.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise

eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is (select one):

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4600
Year 2	4600
Year 3	4600
Year 4	4600
Year 5	4600

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*):

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Military exception	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Military exception

Purpose (*describe*):

The State reserves capacity for military participants and their immediate dependent family members who have been determined program eligible may bypass waitlist upon approval by KDADS. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established SED waiver criteria will be allowed to bypass the waitlist and access services.

The Operating Agency does not have a waiting list for the SED waiver. A waiting list is not anticipated to be put in place. If a waiting list should occur, entrance parameters would be defined at that time with input from stakeholders and providers. Entrance to the waiver is determined by clinical (functional) and financial eligibility with the State of Kansas currently enrolling all eligible participants. The State of Kansas has legislative authority to request increased capacity if the number of applicants exceeds the approved number of eligible.

Describe how the amount of reserved capacity was determined:

There is no data to support this projection of reserved capacity. If the amount of need exceeds reserve capacity, Kansas will submit an amendment to appropriately reflect the number unduplicated persons served.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The Operating Agency does not have a waiting list for the SED waiver. A waiting list is not anticipated to be put in place. If a waiting list should occur, entrance parameters would be defined at that time with input from stakeholders and providers. Entrance to the waiver is determined by clinical (functional) and financial eligibility with the State of Kansas currently enrolling all eligible participants. The State of Kansas has legislative authority to request increased capacity if the number of applicants exceeds the approved number of eligible.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Reasonable classification group of individuals under age 21 who meet the income and resource requirements of AFDC covered under 42 CFR 435.222 defined as children under age 21 who if not for the provision of HCBS waiver services would otherwise be institutionalized.

Parents and other caretaker relatives (42 CFR 435.110) and children (CFR 435.118).

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

- i. Allowance for the needs of the waiver participant (select one):**

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons*(select one):***300% of the SSI Federal Benefit Rate (FBR)****A percentage of the FBR, which is less than 300%**Specify the percentage: **A dollar amount which is less than 300%.**Specify dollar amount: **A percentage of the Federal poverty level**Specify percentage: **Other standard included under the state Plan***Specify:***The following dollar amount**Specify dollar amount: If this amount changes, this item will be revised.**The following formula is used to determine the needs allowance:***Specify:***Other***Specify:*

ii. Allowance for the spouse only (select one):

Not Applicable**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:***Specify:***Specify the amount of the allowance (select one):****SSI standard****Optional state supplement standard**

Medically needy income standard**The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

300% of SSI

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from

the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's

allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

CMHCs are the entities eligible to evaluate children/youth for the SED waiver by completing the initial clinical eligibility packet. They serve as the functional contractor for the SED Waiver. The CMHC must employ qualified mental health professionals to perform the LOC evaluations and reevaluations. A third party contractor will be responsible for being present during a statistically significant sample of new clinical eligibility assessments. The contractor will sit in during the evaluation conducted by the CMHC and fill out their own CAFAS during this time. The CMHC and contractor will score the assessments independently of each other to ensure the CAFAS is administered correctly, found to be valid, and that the client meets SED functional eligibility criteria.

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the

educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The following Qualified Mental Health Professionals may determine initial clinical (functional) eligibility: physicians (MD or DO), advanced registered nurse practitioners, and qualified mental health provider (as defined by K.S.A 59-2946). These individuals must have a license in good standing to practice in Kansas.

(j) Qualified Mental Health Professional means a physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist under a contract with a participating mental health center, a licensed masters level psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, a licensed clinical professional counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing, who is employed by a participating mental health center and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center.

The third party contractor must be a licensed master's level psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, a licensed clinical professional counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Level of Care Criteria is determined through the utilization of two assessment tools, as well as the clinical judgment of a qualified mental health provider. The two assessment tools are the Child Behavior Checklist(CBCL) and the Child and Adolescent Functional Assessment Scale (CAFAS).

The CBCL (Achenbach, 1991a) has been identified as the most reliable and valid parent report measure currently available for assessing children's emotional and behavioral problems (Reitman, Hummel, Franz, & Gross, 1998). Information concerning the child's behavior during the previous six months is obtained directly from the primary caregiver. The CBCL consists of 118 problem behavior items categorized as internalizing or externalizing behaviors. Internalizing behaviors include sadness, depression, and anxiety. Externalizing behaviors include opposition, aggressiveness, and hyperactivity. Scoring procedures using Achenbach's Cross-Informant Scoring Program (Achenbach, 1996) generate standardized scores for eight syndrome subscales, two broadband syndrome scores (internalizing behavior and externalizing behavior), a total problems score, a total competence score, and three competence subscales (activities, social, and school). Internalizing behavior scores are derived from the subscales assessing withdrawal, somatic complaints, and anxious/depressed behaviors, and externalizing behavior scores are derived from the delinquent and aggressive subscales. Internalizing, externalizing, and total problems scale T-scores are considered in the clinical range if they are above 63, while scores from 60 to 63 are borderline. Scores in the clinical range indicate a need for clinical care.

The CBCL is completed by the parents or caregivers and is scored by the Community Mental Health Center Staff. A minimum score of 70 must be achieved on any of the 3 subscales to qualify. Teacher Report and Youth Self Report Forms may also be utilized when appropriate. There is an exception process for scores that fall between 63-69. Exceptions are completed by the qualified mental health provider and then submitted for review by the Operating Agency. Exceptions must provide substantiating evidence that a child/youth requires the level of care provided in an inpatient psychiatric hospital level of care in the absence of supports assessed through the SED waiver although scores were under the qualifying range.

The Child & Adolescent Functional Assessment Scale (CAFAS) is a rating scale, which assesses a youths degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems. One of its primary purposes is to assign cases to the appropriate level of care. The CAFAS is organized into eight scales for rating the child: school/work, home, community, behavior towards others, moods and emotions, substance abuse, self-harm, and thinking. A total score is derived for which there are general interpretive guidelines. When using the CAFAS, a score of 0 indicates minimal or no impairment, 10-mild impairment, 20-moderate impairment, and 30-severe impairment in a given domain (Hodges, 1990a). The eight psychosocial subscales scores are then summed to produce a total score ranging from 0 to 240. When combining the eight subscale scores to generate a total functioning score, total scores of 40 or below indicate minimal impairment; scores from 50 to 90 indicate moderate impairment, while scores from 100 to 130 indicate marked impairment and those 140 or higher indicate severe impairment. In addition, scores above the clinical cutoff of 40 are considered to indicate impairment in social functioning at a level requiring clinical care. A minimum qualifying score of 100 or a score of 30 on any two subscales is required to be clinically eligible for the SED waiver.

The CAFAS is completed by a qualified mental health professional at the CMHC. A total score of 100 or a score of 30 on any two subscales must be met. There is no exception process for CAFAS scores.

The initial clinical eligibility packet includes diagnostic information, a narrative summary of CMHC clinical assessment, a narrative summary of the current evidence supporting the clients need for the level of care, and if needed, a narrative summary providing evidence for request to an exception to minimum and maximum age criteria, and CBCL scores within the clinical range.

A qualified mental health professional reviews the participants clinical eligibility on an annual basis to determine if the participant continues to be at risk for an inpatient psychiatric hospitalization level of care. The CMHC maintains this documentation in the clinical chart. This information is subject to review during the regularly occurring SED waiver chart reviews of the MCOs by the State. MCO care coordinators will assess each waiver participant's medical necessity for waiver services.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the

state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The Community Mental Health Center Screening Form is utilized to screen for a variety of intensive inpatient psychiatric services. The form includes information on presenting problem, risk factors, clinical impressions, and inpatient criteria. The form is not based on a standardized tool or assessment, but solely on the self-report of the participant or family and the clinical judgment of qualified mental health practitioner. The Community Mental Health Center Screening Form is the instrument used to assess for institutional level of care.

Kansas uses the initial clinical eligibility packet to determine level of care for the SED waiver. The initial clinical eligibility packet includes assessment information and the clinical impression of the qualified mental health professional, specifically a narrative summary of the clinical assessment and a narrative summary of the current evidence supporting the participants need for the level of care provided in an inpatient psychiatric hospital. In addition, the initial clinical eligibility packet includes the utilization of two normed and validated clinical assessments, the Child Behavior Checklist (CBCL) and the Child and Adolescent Functional Assessment Scale (CAFAS).

Kansas's initial clinical eligibility packet is a more stringent instrument based on nationally normed and validated clinical assessments. All participants receiving SED waiver services meet minimum scores in the clinical range on these standardized assessments (CBCL and CAFAS) and all participants receiving SED waiver services have a clinical need comparable to those served within inpatient psychiatric hospitals.

Reliability of the CMHC screening tool used to evaluate institutional level of care was established in 1997 based on the data provided by two systems of care initiatives in Kansas, the KanFocus and ComCare projects. In the 2005 independent review of the SED waiver completed by the University of Kansas, it was found that the waiver is intended to serve consumers with clinically significant problems and intense needs who are at risk for hospitalization. The above findings over time indicate that this target population is being served under that waiver, as intended. (Barfield, et al., 2005)

The State uses the Community Mental Health Center Screening Form to determine admission to a child's state hospital alternative. These settings are inpatient, institutional alternatives to the state mental health hospitals. These institutional state hospital alternatives are used because of the age requirement for admission into state mental hospitals. The CMHC Screening Form reviews three criteria levels for admission in the state hospital alternative setting. These criteria include: Self-care failure/self-injury, diagnosis, and clinical needs. These criteria directly co-relate to the measures used for the SED functional eligibility instrument. Given these co-relations the institutional instrument and functional eligibility instrument are directly comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Functional Assessment: All participants must meet minimum scores on the Child Behavior Checklist (CBCL) and Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS can only be administered and scored by a qualified mental health professional. In the initial evaluation, the QMHP conducts standard assessments (CBCL and CAFAS), a clinical narrative, and clinical indication that the youth is determined to be in need of inpatient psychiatric hospitalization in the absence of SED waiver services. All of the initial evaluation is captured in the Initial Clinical Eligibility Packet (ICEP).

Annual Reevaluation: Clinical eligibility for the SED waiver is reevaluated on an annual basis. The format for reevaluating the level of care is guided by the qualified mental health professional's clinical evaluation of continued risk of inpatient psychiatric hospitalization absent SED waiver services and the progress toward goals and objectives. The reevaluation process does differ from the initial evaluation. The reevaluation focuses on whether the participant continues to be in need of inpatient psychiatric hospitalization without SED waiver services. This clinical narrative is captured on the CBCL form and if need be the CAFAS form. The annual level of care continues to require a QMHP as the assessment is based on current diagnosis and level of functioning. Since the SED Waiver is a program designated to reduce inpatient psychiatric hospitalization, it is important to note that medical necessity for hospitalization is based upon risk for the youth and functioning. So the annual level of care requires the same level of clinical assessment as the inpatient hospitalization that the waiver is intended to offset. The annual reevaluation differs from the initial evaluation as it is based primarily off of the QMHPs' clinical judgment of progress on the SED waiver.

Notice of Action: When a participant is found clinically eligible or ineligible during the initial evaluation or the annual reevaluation, the parents or caregivers of the participant and/or the participant will receive a Notice of Action advising the status of clinical eligibility. All clinical eligibility documentation including the initial evaluation, the annual reevaluation, and the Notice of Action are to be maintained in the participants clinical record at the CMHC.

KDADS has proposed the following timeline to implement the third party contractor agreement.

Day 181- CMS has approved the conflict mitigation.

Day 180- An RFP for the Assessment Validation Contractor has been constructed and reviewed.

Day 150- RFP is posted by the Department of Administration (DofA).^{*} KDADS answers questions and concerns around the RFP.

Day 90- KDADS will review submitted RFP proposals and interview potential contractors.

Day 60- KDADS will select a contractor. KDADS will work with the contractor to reach an agreement.

Day 30- KDADS will work with the chosen contractor, MCOs, and CMHC partners to train and prepare for a live launch.

Day 0- Conflict free resolution will go live with the third party contractor working in conjunction with the CMHC partners.

^{*}RFP posting is dependent on the Dept. of Administration Division of Purchases. Timeline will be affected by timely posting of RFP by DofA. Kansas will reach out to CMS if updates to the timeline need to occur.

KDHE/KDADS has proposed the following timeline for amending the MCO contract if needed.

Day 120- KDADS/KDHE will work with MCO's to evaluate the current contract and make changes if needed.

Day 90- KDADS/KDHE will work with MCO's to prepare for new task of POC development.

Day 0-MCO contract submitted to CMS for approval if changes needed.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

The provider that is responsible for performing annual reevaluations must upload the reevaluation information into the State's database. This ensures that all reevaluations are done in a timely manner and allows KDADS to identify and remediate any outstanding reevaluations.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are maintained at the CMHC per K.A.R 30-60-57(c):

(c)Records demonstrating the center's compliance with this regulation shall be centrally maintained for at least five years. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)"

Records are maintained by the provider responsible for performing the initial eligibility determination and annual reevaluation. The state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services N = Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D = Total number of enrolled waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

Other-Operating Agency's data systems/State Data System application and Managed Care Organizations (MCOs) encounter data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>Contracted Assessors and Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Contracted assessors participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool
N = Number of waiver participants whose Level of Care determinations used the approved screening tool
D = Number of waiver participants who had a Level of Care determination

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>Contracted assessors</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Contracted assessors participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

Performance Measure:

Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied N = Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D = Number of initial Level of Care determinations

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95%
Other Specify: <div>Contracted assessors</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>Contracted assessors participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Number and percent of initial Level of Care (LOC) determinations made by a

qualified assessor N = Number of initial Level of Care (LOC) determinations made by a qualified assessor D = Number of initial Level of Care determinations

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>Contracted assessors</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Contracted assessors participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

Performance Measure:

Number and percent of third party contractor level of care (LOC) determinations found to be valid. N= number of LOC assessments found valid by a third party contractor. D= total number of LOC assessments completed by a third party contractor.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> 95% </div>

Other Specify: <div>Contracted Assessors</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>Contracted assessors participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These performance measures will be included as part of the comprehensive KanCare State Quality Improvement Strategy, and assessed quarterly with follow remediation as necessary. In addition, the performance of the functional contractor with Kansas will be monitored on an ongoing basis by the state and the MCOs to ensure compliance with the contract requirements.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency. State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: KanCare MCOs participate in analysis	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the plan of care development process, the CMHC selected by the consumer informs eligible consumers, or their legal representatives, of feasible alternatives for institutional care, and documents their choice of either institutional or home and community-based waiver services utilizing the SED Waiver Family Choice Assurance Document.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

SED Waiver Family Choice Assurance Forms are documented and maintained by the consumer's chosen CMHC in the consumer's case file.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient participants, states are required to capture language preference information.

The State of Kansas defines prevalent non-English languages as languages spoken by a significant number of potential enrollees and enrollees. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that participants may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the participant in his/her spoken language, and/or access to a phone-based translation services so that someone is readily available to communicate orally with the participant in his/her spoken language. (K.A.R. 30-60-15).

Access to a phone-based translation system is under contract with KDADS and available statewide.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case

management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Attendant Care		
Statutory Service	Independent Living/Skills Building		
Statutory Service	Short-Term Respite Care		
Other Service	Parent Support and Training		
Other Service	Professional Resource Family Care		
Other Service	Wraparound Facilitation		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

This service enables the participant to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness. Assistance is in the form of direct support, supervision and/or cuing so that the participant performs the task by him/her self. Such assistance most often relates to performance of Activities for Daily Living and Instrumental Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community. Services should generally occur in community locations where the participant lives, works, attend schools, and/or socializes. Services provided at a work site must not be job tasks oriented. Services provided in an educational setting must not be educational in purpose or duplicate services required to be provided by the educational institution. Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual or developmental disabilities, or institution for mental disease are non-covered. Services must be recommended by a wraparound team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the participant's individualized plan of care. Participants under the age of 21 who are eligible to receive EPSDT services may access those services through the Medicaid state plan.

Transportation is provided as a part of this waiver service only between the participant's place of residence and other service sites in the community. The cost of transportation is included in the rate paid to providers of this service. KanCare MCOs will be responsible for all other transportation needs for the participant.

Service must be intended to achieve the goals and/or objectives identified in the participant's individualized plan of care.

1. Receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such shall be available at all times to provide back up, support, and/or consultation. Attendant care for the SED waiver is provided to a child whose mental health disorder affects their activities of daily living. It is specialized in the way it is provided based on how the child's therapist is working with the child. SED attendant care is designed to reinforce techniques from the child's primary therapist. SED attendant care is designed to help the child cope with their mental illness and provide them with someone to help work through emotional disturbances caused by the mental health disorder. Attendant care on the SED waiver is designed to continue working on skills set by the QMHP or LMHP to help the child with their mental health diagnosis. The clinical supervision is necessary to ensure the correct skills are being utilized. The SED waiver allows children to continue to receive therapy services from providers other than therapists at the CMHC. The Contractor-Designated LMHP is a licensed mental health professional that is providing therapy services to a child on the SED waiver. The LMHP in these cases is not directly associated with the CMHC.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits on Attendant Care.

Attendant Care does not duplicate any Individuals with Disabilities Education Act(IDEA) services.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Attendant Care Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Attendant Care Worker

Provider Qualifications

License (*specify*):

The provider licensure qualifications are pursuant to the language in the Kansas Managed Care Organization contract. This includes a licensure requirement of a community mental health center as defined by KSA 19-4001.

Certificate (*specify*):

Not applicable.

Other Standard (*specify*):

Individual provider must have a high school diploma or equivalent.

Must be 18 years of age and at least 3 years older than the youth. Completion of state approved training according to the curriculum approved by the Operating Agency prior to providing the service.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Independent Living/Skills Building

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Independent Living/Skills Building services are designed to assist participants who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings. Participants under the age of 21 who are eligible to receive EPSDT services may access those services through the Medicaid state plan. Independent Living/Skills Building activities are provided in partnership with participants to help them arrange for the services they need to become employed, find transportation and housing, and continue their education. Services are individualized according to each participant's strengths, interests, skills, and goals as specified in the plan of care. Independent Living/Skills Building activities should take place in the community. This service can be utilized to train and cue normal activities of daily living. Housekeeping, homemaking, or basic services solely for the convenience of the participant receiving Independent Living/Skills Building are not covered.

The following are examples of appropriate community settings rather than an all inclusive list: a grocery store to teach the participant how to shop for food, a clothing store to teach the participant what type of clothing is appropriate for job interviews, an unemployment office to assist in seeking jobs or assist the participant in completing applications for jobs, apartment complexes to seek out housing opportunities, and laundromats to teach the participant how to wash clothing. This is not an all inclusive list. Other appropriate activities can be provided in any other community setting as identified through the plan of care process.

Transportation is provided between the participants place of residence and other services sites or places in the community. The cost of transportation is included in the rate paid to providers of this service.

Independent Living/Skills Building does not duplicate any other Medicaid state plan service or service otherwise available to participants at no cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits on Independent Living/Skills Building.

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Transition Coordinator

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Independent Living/Skills Building****Provider Category:**

Agency

Provider Type:

Transition Coordinator

Provider Qualifications**License** (*specify*):

The provider licensure qualifications are pursuant to the language in the Kansas Managed Care Organization contract. This includes a licensure requirement of a community mental health center as defined by KSA 19-4001.

Certificate (*specify*):

Not applicable.

Other Standard (*specify*):

Individual provider must have a high school diploma or equivalent.

Must be 21 years of age.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Family Services child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Completion of Independent Living/Skills Building training according to a curriculum approved by the Operating Agency prior to providing the service.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Short-Term Respite Care

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:**Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Short-Term Respite Care provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to the parents or caregivers of a participant with a serious emotional disturbance. The service is designed to help meet the needs of the primary caregiver, as well as the identified participant. Normal activities of daily living are considered content of the service when providing respite care. These include support in the home, after school, or at night; transportation to and from school, medical appointments, or other community-based activities, or any combination of the above. The cost of transportation is included in the rate paid to providers of this services. Short-Term Respite Care can be provided in the participants home or place of residence or provided in other community settings. Other community settings include Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds. Short-Term Respite Services provided by or in an IMD are not covered. The participant must be present when providing Short-Term Respite Care.

Short-Term Respite Care may not be provided simultaneously with Professional Resource Family Care services and does not duplicate any other Medicaid state plan service, or service otherwise available to participants at no cost.

FFP is not claimed for the cost of room & board.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Foster care children and youth on the SED waiver will not be able to access short term respite care. This service is available to children and youth in foster care under the foster care contract.

This service cannot be provided in a Youth Residential Center 1 or a Youth Residential Center 2.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Care Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Short-Term Respite Care

Provider Category:

Agency

Provider Type:

Respite Care Provider

Provider Qualifications

License (*specify*):

The provider licensure qualifications are pursuant to the language in the Kansas Managed Care Organization contract. This includes a licensure requirement of a community mental health center as defined by KSA 19-4001.

In an overnight setting outside the family or relative's home, the home or facility must meet applicable Kansas Department of Children and Families licensure requirements.

Certificate (*specify*):

CPR.

Crisis Prevention/Management (example: CPI, Mandt, etc.).

Other Standard (*specify*):

Individual providers must have a high school diploma or equivalent.

Must be 21 years of age.

Completion of Short-Term Respite Training according to the curriculum approved by the Operating Agency prior to providing the service.

First Aid.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

KanCare MCOs and KDADS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Parent Support and Training

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training
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Category 2:

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Sub-Category 2:

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Category 3:

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Sub-Category 3:

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Service Definition (Scope):**Category 4:**

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Sub-Category 4:

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Parent Support and Training is designed to provide families of children who have been identified to have a serious emotional disturbance and in need of or at risk of more intensive level of care such as a state psychiatric hospitalization, psychiatric residential treatment facility treatment (PRTF), or brief hospitalization or crisis services the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Parent Support and Training can be provided anywhere in the community that is agreeable to the individual.

This is a training and support service necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the participant.

For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting.

1. Support, coaching and training provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member.
2. This involves helping the families identify and use healthy coping strategies to decrease caregiver strain, improve relationships with family, peers and community members and increase social supports;
3. Assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the participant in relation to their mental illness and treatment;
4. Development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the participant's symptom/behavior management;
5. Assist the family in understanding various requirements of the waiver or grant process, such as the crisis plan and plan of care process;
6. Educational information and understanding on the participant's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the participant with mental illness while living in the community; provide information on supportive resources in the community;
7. Service must be intended to achieve the goals and/or objectives identified in the participant's individualized plan of care.

Parent Support and Training does not duplicate any other Medicaid state plan service or service otherwise available to recipients at no cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits on Parent Support and Training. Operationally, individuals receiving Parent Support Training do not simultaneously receive Professional Resource Family Care.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Parent Support Specialist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Parent Support and Training

Provider Category:

Agency

Provider Type:

Parent Support Specialist

Provider Qualifications

License (*specify*):

The provider licensure qualifications are pursuant to the language in the Kansas Managed Care Organization contract. This includes a licensure requirement of a community mental health center as defined by KSA 19-4001.

Certificate (*specify*):

Not applicable.

Other Standard (*specify*):

Individual providers must have a high school diploma or equivalent.

Must be 21 years of age. Preference is given to Parents or caregivers of children with SED.

Completion of Parent Support Training according to a curriculum approved by the Operating Agency within one year of hire.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Peer to Peer provider must be associated with the CMHC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):**Category 4:**

Sub-Category 4:

Professional Resource Family Care is intended to provide intensive supportive resources for the participant and his or her family. This service offers intensive family-based support for the participant's family through the utilization of a co-parenting approach provided to the participant in a surrogate family setting. The goal is to support the participant and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the participant, there is regular contact with the family to prepare for the participant's return and his or her ongoing needs as part of the family. It is expected that the participant, family, and the professional resource family are integral members of the participants individual treatment team.

Transportation is provided between the participants place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this services.

Professional Resource Family Care can be provided anywhere in the community that is agreeable to the individual.

Professional Resource Family Care may not be provided simultaneously with Short-Term Respite Care and does not duplicate any other Medicaid state plan service or service otherwise available to participants at no cost.

FFP is not claimed for the cost of room & board.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Foster care children and youth on the SED waiver will not be able to access Professional Resource Family Care. This service is available to foster care children and is named "Therapeutic Foster Care" under the foster care contract.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Professional Resource Family

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Professional Resource Family Care

Provider Category:

Agency

Provider Type:

Professional Resource Family

Provider Qualifications

License (specify):

The provider licensure qualifications are pursuant to the language in the Kansas Managed Care Organization contract. This includes a licensure requirement of a community mental health center as defined by KSA 19-4001.

Family Home Setting licensed by Kansas Department of Children and Families.

Certificate (specify):

First Aid.

Crisis Prevention/Management (Example: CPI, Mandt, etc.).

Other Standard (specify):

Individual providers must have a high school diploma or equivalent.

Must be 21 years of age.

Completion of the state approved training according to a curriculum approved by the Operating Agency prior to providing the service.

CPR.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Wraparound Facilitation

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

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Category 3:**Sub-Category 3:**

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Service Definition (Scope):**Category 4:****Sub-Category 4:**

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Wraparound facilitation is provided in addition to targeted case management to address the unique needs of a participant living in the community. Wraparound facilitation is used to bring the managed care organization, participant, family and community members together to discuss and update the individualized Plan of Care at the minimum of yearly and more frequently when changes in the participant's circumstances warrant changes in the plan of care. Wraparound facilitation cannot duplicate TCM services. Wraparound facilitation is intended to form the wraparound team for the purpose of assisting in the update of the plan of care. TCM assist individuals with access to medical, social educational and other services outside of the waiver. The KanCare MCOs have delegated the provision of targeted case management to the state's community mental health centers. The Targeted Case Manager (TCM) and Wrap Around Facilitator (WAF) cannot be the same person. However, a TCM for one participant may be a WAF for a different participant.

The function of the wraparound facilitator is to form the wraparound team consisting of the participant's family, extended family, other community members involved with the participant's daily life, and the participant's chosen MCO, for the purpose of updating the community-based, individualized plan of care. This includes working with the family to identify who should be involved in the wraparound team and assembly of the wraparound team when subsequent plan of care review and revision is needed, at minimum yearly to review the plan of care and more frequently when changes in the participant's circumstances warrant changes in the plan of care. The wraparound facilitator will emphasize building collaboration and ongoing coordination among the parents or caregivers, family members, service providers, MCO care coordinator, and other formal and informal community resources identified by the family. The wraparound facilitator will promote flexibility to ensure appropriate and effective service delivery to the participant and parents or caregivers. The wraparound facilitator provides ongoing wraparound services through the participants time on the SED waiver. Facilitators will be certified after completion of specialized training in the wraparound philosophy, waiver rules and processes, waiver eligibility and associated paperwork, structure of the wraparound team, and wraparound meeting facilitation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits on wraparound facilitation.

Wraparound facilitation cannot duplicate any services provided by targeted case management.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Wraparound Facilitator

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Wraparound Facilitation

Provider Category:

Agency

Provider Type:

Wraparound Facilitator

Provider Qualifications

License (*specify*):

The provider licensure qualifications are pursuant to the language in the Kansas Managed Care Organization contract. This includes a licensure requirement of a community mental health center as defined by KSA 19-4001.

Certificate (*specify*):

Not applicable.

Other Standard (*specify*):

Individual providers must have at least a bachelor's degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience substituting for one year of education.

Completion of Wraparound Facilitation training curriculum as approved by the Operating Agency prior to the delivery of service.

Pass a Kansas Bureau of Investigation background check, the DCF child and adult abuse registry checks, and motor vehicle Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management services for this waiver will continue to be provided by the community mental health centers (CMHC) across Kansas, who have clinical and programmatic expertise and experience regarding the needs of people who use this waiver, in collaboration with the care managers at the KanCare MCOs to address the needs of each waiver participant. The MCO's must approve all plans of care and services listed in the plan of care prior to a CMHC providing services to a youth.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The State requires that all providers of SED waiver services undergo a criminal background check with the Kansas Bureau of Investigation and motor vehicle check. The Operating Agency interviews the Human Resources Director at the CMHC to determine whether the mandatory investigations have been conducted. The Operating Agency reviews the CMHC personnel files to ensure the results of the mandatory investigations are on file with the CMHC.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (*select one*):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The contractor / sub contractor and /or provider must check all individuals against the Kansas Department for Children and Families (DCF) child abuse, adult abuse and nurses aid registries. DCF Children and Adults Services maintain the registries for all confirmed perpetrators.

- Eligibility Determination
- Attendant Care Provider
- Short-Term Respite Care Provider
- Parent Support and Training Provider
- Professional Resource Family Care Provider
- Wraparound Facilitator

The contractor / sub contractors and /or providers must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6

The contractor/subcontractor and/or provider refer to the credentialed organizations that the MCO contracts with in order to provide the SED services.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a

legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Participants of HCBS-SED waiver services have the right to choose who provides their services, within established guidelines regarding provider qualifications. Any qualified providers of those services may enroll through the Medicaid agency, Kansas Department of Health and Environment (KDHE), for the Kansas Medical Assistance Program; and also must contract with, and meet the contracting terms of, the KanCare MCOs. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver. The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care. When potential providers contact HPE Provider Enrollment, they can request an enrollment packet that includes information such as the provider requirements for each service or make application on-line.

The CMHCs enroll through the Medicaid fiscal agent, Hewlett-Packard Enterprise Services (HPES) and also must meet the contract requirements of the MCOs. CMHCs have access to information regarding requirements and procedures through outreach with the MCOs, through the MCO provider manuals and the MCO's website has detailed information on these topics.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new licensed waiver provider applicants that initially met licensure requirements and other waiver standards prior to furnishing waiver services
N = Number of new licensed waiver provider applicants that initially met licensure requirements and other waiver standards prior to furnishing waiver services
D = Number of all new licensed/certified waiver providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

KanCare Managed Care Organization (MCO) reports and record reviews

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (check each that applies):
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collection/generation (check each that applies):	(check each that applies):	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards

N = Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
D = Number of enrolled licensed/certified waiver providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block;">KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; display: inline-block;">Proportionate by MCO</div>

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services $N =$ Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services $D =$ Number of all new non-licensed/non-certified providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

Performance Measure:

Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
 $N = \text{Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements}$
 $D = \text{Number of enrolled non-licensed/non-certified providers}$

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95%
Other Specify: <div>KanCare Managed Care Organizations</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is*

conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of active providers that meet training requirements N =

Number of providers that meet training requirements D = Number of active providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify:	

	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

Data analysis is completed and remediated for any assurance or sub-assurance less than 100%. KDADS staff will notify the MCO of areas below 100% with details of each finding. KDADS staff will notify the MCO if any findings are below 87%, those that fall below 87% are required to also include a quality improvement project. The MCO will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by KDADS staff for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, KDADS staff will continue to monitor through Quality Reviews to ensure compliance.

Any abuse, neglect or exploitation issue will be immediately reported to the designated state reporting agency. Any substantiated case of ANE will require remediation. The remediation plan must address how health and safety needs have been addressed including immediate corrective action and ongoing plan to prevent ANE. Findings or concerns on a specific case identified through the review by Quality Management System (QMS) will be entered in Quality Review Tracker (QRT). Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the applicable Program Manager.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: KanCare Managed Care Organizations (MCOs)	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

KDADS has proposed a statewide transition plan for residential and non-residential settings in compliance with federal HCBS requirements, upon approval from CMS.

Please see attachment 2 for the HCBS-SED Transition and statewide Transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care (POC)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Kansas has contracted with three managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The MCOs are responsible for plan of care development, and use their internal staff to provide that service. Kansas requires that conflict of interest be mitigated, and recognizes that the primary way in which that mitigation has been achieved is by separating from service providers the plan of care development, and making that an MCO function. Some of the additional safeguards are in place to ensure that there is no conflict of interest in this function include the operational strategies for each MCO that are described in detail at Section D.1.d of this appendix.

The MCO ensures that the participant and or those whom the participant wishes to be part of the plan of care, has the opportunity to engage and/or direct the plan of care development. The MCO in conjunction with the Wraparound facilitator will provide adequate notice to those involved in the plan of care development and ensure the process is done in a timely manner. The MCO will also ensure that the needs of the individual are assessed and services meet the assessed needs and that responsibility of the plan of care is identified with the correct providers.

Regarding Amerigroup: Service plans for Amerigroup members in waivers are developed by Service Coordinators who must have at least two years of experience working with individuals with chronic illness, comorbidities, and/or disabilities in a Service Coordinator, Case Management, Advocate or similar role. Preferred qualifications include experience in home health, health care, discharge planning, and behavioral health, collaborating with nursing facilities, community resources, and/or other home and community-based agencies. Experience working with Medicare, Medicaid and managed care programs is also preferred.

While a Master's degree is preferred, education/experience for Service Coordinators must include one of the following

- Bachelor's degree from an accredited college or university in Nursing, Social Work, Counseling, Special Education, Sociology, Psychology, or a closely related field;
- Bachelor's Degree in an unrelated field and at least two years of case management experience; or
- In lieu of a bachelor's degree, six years of case management experience

Regarding Sunflower: Sunflower employs an Integrated Care Team approach for Service Plan Development. Teams conducting care coordination/care management are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers have primary responsibility for ensuring service plan development. Care managers are Registered Nurses and Master's level Behavioral Health clinicians with care management experience and, as applicable to the position, expertise including adult and pediatric medical, maternity and behavioral health/psychiatric care. Each Member receiving Care Management is assigned a lead Care Manager who oversees the Member's care. This includes, but is not limited to, participation in inpatient rounds with concurrent review nurses to assist with discharge and transitional care planning, and coordination with the Member's treating providers. Care Managers perform assessments, work with Members/caregivers to develop care plans, and provide educational resources and follow up in conjunction with the Integrated Care Team.

Regarding United: Service plans are developed by licensed nurses or licensed social workers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The CMHC staff contacts the participant and/or the parent or caregivers of the participant before the plan of care (POC) meeting. During this contact the CMHC staff assures the delivery of the SED waiver brochure which describes the waiver services, free choice of providers, and how to report abuse and neglect. Each waiver participant is a member of one of the KanCare MCOs and is provided a member handbook. In the member handbook, the participant's rights and responsibilities are identified.

The CMHC staff in conjunction with the MCO Care Coordinator informs the participant and the parents or caregivers of the participant of the available resources that may be included in the plan of care.

CMHCs provide information about the services and supports available to the participant and how the SED Waiver can benefit the participant and parents or caregivers of the participant. The MCO care coordinator guides the development of the plan of care during the plan of care meeting. The participant and parents or caregivers of the participant choose the members of their plan of care meeting in a participant-driven approach to the treatment process. Kansas utilizes the strengths model which views the participant and parents or caregivers of the participant as the expert on the strengths and needs of the participant. The plan of care team identifies the strengths, needs, preferences, and desired outcomes of the participant and decides frequency and duration of services and supports. The plan is guided around the strengths and needs of the participant. The plan of care must be updated every 90 days or sooner if needed. The participant and parents or caregivers of the participant have the ability to request a meeting to update the plan of care at any time should needs or circumstances change. The participant and parents or caregivers of the participant ultimately determine participation in the plan of care development, the identification of plan of care goals, and the designation of plan of care services and supports.

The MCO care coordinator is ultimately responsible for the service plan development and updates.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Plan Development

Regulation K.A.R. 30-60-62 requires a treatment plan or plan of care (POC) be in place within 14 days of intake for any participant accessing services through Community Mental Health Centers (CMHCs). If new to the CMHC provider system, the participant will receive services based upon this POC while the POC process is being completed. As soon as the Family Choice Assurance Document (FCAD) is signed the CMHC will work with the family to have an initial meeting to obtain strengths/needs and refer to non-waiver-based services, assist with the Medicaid application, etc. The CMHC then develops the initial POC based on the strength/needs identified by parent and child. The waiver-specific POC is developed by the MCO care coordinator. The POC meeting is scheduled at the earliest convenience of the participant and parents or caregivers of the participant within 30 days of creating the interim POC. During the meeting, a POC is developed that incorporates both formalized and natural supports to address the identified goals of the POC.

b) Assessment Types

A formal assessment of needs, abilities, and health status is conducted using a Strengths and Needs Assessment contained in the POC and is conducted as a part of the MCO care coordination process. The Strengths and Needs Assessment addresses the following domains: home, community, financial/economic, health, legal, leisure/recreation, vocational/educational, socialization, and other. Input into the Strengths and Needs Assessment is given by the participant and parents or caregivers of the participant.

Goal development is directly related to the Strengths and Needs Assessment. Goals are established based upon the participant's needs and interventions for goals are built upon the participant's identified strengths. The POC team identifies goals and interventions based upon the Strengths and Needs Assessment. POC goals identified by the participant and parents or caregivers of the participant as the most pertinent or pressing are given preference. The POC team also identifies the preferences and desired outcomes of the youth and incorporates those items into the POC.

c) Participant Education on Available Waiver Services

The CMHC informs the participant and their parents or caregivers of the array of services that may be accessed through the SED waiver during the initial assessment, eligibility determination process and preliminary discussions of treatment. The array of services available to the family includes waiver-specific services and services available in the system of care outside of the SED waiver. Examples of such services would be traditional mental health services like medication management and individual therapy. Non-traditional community-based services such as case management and psychosocial treatment group would also be available. Natural occurring supports outside of the community mental health system are also utilized to support the family. Formalized services are not incorporated to take the place of existing or identified natural supports.

d) POC Development Process

The POC development process ensures that the POC addresses the participant's needs, goals, and preferences by using participant-specific information from both the assessment and direct input from the participant and any significant others to guide the process. The POC development process is further ensured by the direct involvement of, and monitoring by, the participant and/or legal representative, and any persons identified by the participant to be involved in the plan development process. Person-centeredness of the POC is reinforced through regulation which requires participant participation in, and approval of, the POC (K.A.R. 30-5-309). In addition, regulation K.A.R. 30-60-62 also requires that CMHCs operate from one integrated treatment plan. This reinforces the wraparound process and results in the POC encompassing all services that may be accessed through the CMHC. The primary source of information gathered about the participant is the participant himself/herself and family. If needed, with the participant's signed release of information, the MCO may contact other information sources such as physicians, other health care providers, and/or family members. Regulation K.A.R. 30-60-62 requires the participant and parents or caregivers of the participant to be involved in the development of the POC. Participation is documented through the signatures of the participant and parents or caregivers of the participant on the POC. Participant/Guardian signature does not constitute approval or denial of the POC. Participant/Guardian signatures indicate an understanding of POC contents and confirms participation in the creation process. A copy of the POC developed during the face-to-face meeting is provided to the participant or participant-selected representative at the time of the meeting. The MCO shall send the POC and Notice of Action (NOA) to all involved parties, i.e., the participant, providers, activated durable power of attorney (DPOA), guardian, and conservator.

e) Coordination of Services

CMHC staff coordinate waiver and other services who utilize knowledge of available services, both formal and informal in the participant's community, as well as information from the participant regarding his/her current utilization of those services as well as other available services including Medicaid health services. Currently utilized services and available community services are taken into consideration as the participant, the MCO care coordinator, and other natural supports design the POC.

The MCO completes the appropriate forms indicating service tasks necessary to enable the participant to live safely in the most integrated environment possible. The MCO shall inform the provider, participant, guardian/DPOA (if applicable), family member, advocate, or other person acting on behalf of the participant of the rate of services and discuss the hours of care to be delivered to the participant. The MCO shall record all pertinent information received verbally or in writing from the participant, staff, or collateral contacts in the case log. The MCO shall send the POC, the identified service tasks to be performed indicated from the POC, and Notice of NOA to all involved parties (i.e., the participant, providers, activated DPOA, guardian, and conservator).

f) Implementation and Monitoring

The POC identifies the assigned task and person responsible for implementing the identified support to attain a specific POC goal. This includes community partners identified by the wraparound team to provide natural supports for the family to meet the participant's needs. Each POC has an identified Crisis Plan section which identifies potential crisis, what action steps (strategies) need to be implemented and the person(s) responsible to mitigate the risk.

The MCO conducts follow-up visits with the participant. The participant's parent or legal guardian is required to report any changes that occur generating updates as needed to adjust services. The participant is involved in the development of the needs assessment with identified care needs and preferences. MCO coordinates other federal and state program resources, including services available to the child through Early Periodic Screening Diagnosis and Treatment (EPSDT) services in the development of the POC.

g) POC Updates

The POC is updated every 90 days in conjunction with a required reassessment using the SED Waiver Annual Evaluation of Level of Care or as is necessary when the participant's needs have increased, decreased, or changed in any way. An increase in services must be justified by a change in the participant's health and safety needs, medical condition, or informal supports.

The participant has the right to make changes to the plan deemed necessary. Changes to the POC can be made at any time to reflect changes in the participant's needs. Upon authorization of the POC, and when changes in status occur, the MCO is required to notify the participant and the participant's parent/guardian of the authorization by use of a NOA form. Thus, all involved parties are informed and serve to monitor and advocate for the needs and wishes of the participant. If at any time, an action is taken related to the POC that does not meet the satisfaction of the participant; the participant may utilize the MCO's grievance process, appeal, or the state fair hearing process that would ultimately ensure the participant's needs are being met.

h) List of Applicable Regulations

- Regulation K.A.R. 30-5-309:
 - o Requires participant participation in and approval of the plan which helps reinforce person-centeredness of the plan.
- Regulation K.A.R. 30-60-62:
 - o Requires a treatment plan or POC be in place within 14 days of intake for any participant accessing services through Community Mental Health Centers (CMHCs).
 - o Requires the participant and parents or caregivers of the participant to be involved in the development of the POC.
 - o Requires that CMHCs operate from one integrated treatment plan. This reinforces the wraparound process and results in the POC encompassing all services that may be accessed through the CMHC.

i) List of MCO Operational Strategies

Kansas has contracted with managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The MCOs are responsible for POC development and will be using their internal staff to provide that service. Some of the additional safeguards that will be in place to ensure that there is no conflict of

interest in this function include the following operational strategies for each MCO:

- Amerigroup:
 - o Care managers (CM) and Service Coordinators (SC) do not have access to financial data such as the rates the providers are paid
 - o CM and SCs cannot adjudicate or adjust claims
 - o Policies and procedures focus on POCs being participant centered and providing choice among network providers
 - o Members get copies of the POC that provide the member the opportunity to identify mistakes and/or complain about CM/SC interaction
 - o Long-Term Services and Supports (LTSS) Participants sign their assessment on iPad
 - o Quality department monitors and trends complaints including those related to SCs
 - o Health Plan conducts CAHPS surveys that include opportunities for participants to express their satisfaction with CM/SC
 - o Health Plan selects a sample of participants per month, including those participating in LTSS, to send EOBs for services billed to conduct fraud surveillance and to drive complaints to the MCO as applicable if they are dissatisfied with their services
 - o MCO LTSS managers audits SC/CM to assure member driven service plans
 - o Participants can appeal decisions related to a reduction of HCBS and any other services
 - o MCO will submit a report to the state, on a for information basis, of members for whom any reduction in the service plan was made and excluding services that are reduced to conform with benefit or program limits, because a participant transitions out of a particular program HCBS program, loses eligibility, or other similar circumstance.
- United Healthcare: All operations, including but not limited to the clinical operations and functions of every UnitedHealthcare Community Plan are designed to ensure no conflict of interest with the Teams that are responsible for Plans of Care, service authorization, monitoring, payment, and business management of the Health Plan. To this end, standard within the Kansas UnitedHealthcare Community Plan the following safeguards exist:
 - o The State of KS (not UnitedHealthcare Community Plan) retains the responsibility for member initial and annual eligibility determinations for waiver programs.
 - o UnitedHealthcare Community Plan has developed a network of contracted HCBS providers to deliver waiver services & does not directly employ any HCBS providers.
 - o Service plans are developed based on member clinical and functional assessment (state approved), analysis of available informal supports, and standardized internal task/hour guidelines. Inter-rater reliability activities including joint member visits are conducted regularly by managers to assure consistency & accuracy of the assessment & service plan development process.
 - o HCBS provider selection is driven by member choice from the network, and if no member preference exists, referrals are made to network providers in the closest geographic proximity who are able to meet the member's preferred schedule.
 - o Prior authorizations are required for all HCBS services and submitted by the assigned care coordinator. A utilization management team separate from the care coordination team completes final reviews of the authorization to assure that the member is eligible for the requested waiver service and that the documentation supports the proposed service plan. Inter-rater reliability activities are also conducted regularly with the utilization management team.
 - o The Team that conducts care coordination and POC development is different from the Team that authorizes care and they have different reporting structures.
 - o All UnitedHealthcare health plans including the Kansas UnitedHealthcare Community Plan offer no compensation for any clinical staff that creates incentives for activities that would deny, limit, or discontinue medically necessary services to any member. POC development and service authorization decisions are based on appropriateness of care and existence of coverage.
- Centene/Sunflower
 - o Safeguards: Sunflower State Health Plan's operations, including but not limited to the clinical operations and functions, are designed to ensure no conflict of interest exist between the teams that are responsible for Service Plans or POC, service authorization, monitoring, payment, and business management of the Health Plan.
 - o HCBS Providers Independence & Member Choice: Sunflower State Health Plan has developed a network of contracted HCBS providers to deliver waiver services and does not directly employ any HCBS providers. Sunflower

State works with the members to ensure member choice from our contracted network of providers. HCBS provider selection is driven by member choice from the network, and if no member preference exists, referrals are made to network providers in the closest geographic proximity who are able to meet the member's preferred schedule. The Case Manager will work closely with the member and our provider network to meet the member's service plan or POC.

- o **Services Plans:** Service Plans are developed based on member clinical and functional assessment tools directed by the state, analysis of support system/community, utilization of members ADLs and IADL measurement, and leveling of care to determine and standardize tasking/hour guidelines for members' Service Plans. Case Management Managers and Director for Waiver programs, will conduct Case Management inter rater reliability ensuring consistency of case management's assessment and Service Plan development. This will be ongoing, reflecting improvement of and training or staff. Prior authorizations are required for all HCBS services and submitted by the assigned care coordinator. The Medical Management team will meet to discuss HCBS service plan ensuring member's eligibility for the requested services. Review of the HRA assessment and additional measuring tools define and support service plan needs. Inter rater reliability activities and training continues ongoing. The Medical Management team consists of CM Manager, BH, Social Worker, RN Case Manager and Medical Director when appropriate regarding the development of care planning and services. Service Plan development and service authorization decisions are based on appropriateness of care and existence of coverage. Sunflower's State Health Plan Care Manager team base service authorizations on appropriateness of care and benefit coverage with the development of the member's Service Plan.
- o **Role Based Security:** Sunflower State Health Plan has in place role-based security to ensure no conflict of interest between the Service Plan or POC development and claims payment. Role based access control (RBAC) allows Sunflower to assign access to our Management Information Systems, in this case TruCare and Amisys Advance, to appropriately authorized personnel based on specific job roles. The claims processing team and clinical teams are two separate functional areas with different job roles and security. For Sunflower, the plans of care are developed in Kansas and the claims are processed in Great Falls, MT.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Each plan of care is required to contain a crisis plan. Crisis plans are developed in conjunction with the plan of care during the POC meeting based upon the individualized preferences of the participant and parents or caregivers of the participant. As with the plan of care itself, the participant and parents or caregivers of the participant may choose to revise the crisis plan at any time they feel it is necessary. Strategies to mitigate risk vary from individual to individual. Strategies may consist of coping skills that may calm the participant such as talking to a parent, listening to music, separating themselves away from what is causing the crisis, etc. Other strategies can consist of using services from another CMHC, receiving non-waiver supports or services, or services from the community other than a CMHC. Each crisis plan is individualized to the participant. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the participant and identified by the POC team.

The crisis plan includes action steps as a backup plan if the crisis cannot be averted. The action steps are developed through the POC development process by the POC team and incorporated in the crisis plan. The action steps may involve contacting natural supports, calling a crisis phone line, or contacting the case manager. Backup plans vary from individual to individual. The backup plans are unique and specifically designed based on the individual's need. Backup plans may consist of using services from a CMHC that is not the individual's primary CMHC or services from the community other than a CMHC. All CMHCs are required through K.A.R 30-60-64 to provide 24-hour/7-day a week crisis response that is readily accessible to participants and their parents or caregivers. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their plan of care in order to have access to the identified information should a crisis occur.

A plan of care is developed in partnership with the participant, family, MCO care coordinator, and POC team. The plan of care includes a crisis plan (risk plan). Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. All Community Mental Health Centers are required to have 24/7 phone crisis response.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants will have free choice of providers within the KanCare structure and may change providers as often as desired. Participants on the SED waiver may receive rehabilitation services at the CMHC, but are not required to utilize a CMHC in an identified geographical area. When a participant becomes eligible for the SED Waiver and is already established with a therapist who is not a member of the network, the CMHC is required to make every effort to arrange for the participant to continue with the same provider if the participant so desires. The provider would be requested to meet the same qualifications as other providers in the network. In addition, if a participant needs a specialized service that is not available through the network, the assigned managed care organization will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, participants will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area. This information is provided in the KanCare health plan's member handbooks which are given to participants upon enrollment in the waiver. Member handbooks are also available on the KanCare health plans websites.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The MCO and the child/family develop a plan of care. This plan is then submitted to the contracted MCO of choice for plan of care approval.

The MCO is responsible for maintaining a copy of an electronic or paper plan of care is to be maintained in the child's file.

Engagement of the interagency monitoring team, brings together leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services on a quarterly basis.

The State Operating Agency Quality Management Staff (QMS) conducts routine oversight of service plans. On-site reviews are conducted, at a minimum, annually. The State Operating Agency QMS conduct ongoing reviews based upon a statistically valid random sample of service plans, at a minimum quarterly. KDHE staff accompany KDADS staff when performing on-site reviews of the MCO documentation which includes authorized plans of care. Critical components of the SSMA and Operating Agency's role in service plan development include:

1. Engagement of the interagency monitoring team, which meets quarterly and brings together agency leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services.
2. Continued participant by the Operating Agency in interagency long-term care meetings to report quality assurance and programmatic activities to SSMA for oversight and collaboration.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

The Eligibility Specialist maintains copies of the original FEI, freedom of choice forms, and the Rights and Responsibilities forms.

The KanCare MCOs maintain the copies of the above mentioned information as well as any additional forms such as; the child/family strengthens and needs assessment, individualized behavioral program and plan of care, detail progress notes, etc., In the child's case file.

Copies are maintained for a minimum period of 3 years as required by 45 CFR 74.53

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The three KanCare contracting managed care organizations are responsible for developing and approving the initial plan of care along with monitoring the implementation of the plan of care that was developed as a partnership between the participant and the CMHC and for ensuring the health and welfare of the participant and assessed with the comprehensive statewide KanCare quality improvement strategy (which includes all of the HCBS waiver performance measures).

On an ongoing basis, the MCOs monitor the plan of care and participant needs to ensure:

- Services are delivered according to the Plan of Care;
- Participants have access to the waiver services indicated on the Plan of Care;
- Participants have free choice of providers;
- Services meet participant's needs;
- Liabilities with self-direction (if applicable)/agency-direction are discussed, and back-up plans are effective;
- Participant's health and safety are assured, to the extent possible; and
- Participants have access to non-waiver services that include health services.

The plan of care is the fundamental tool by which the State will ensure the health and welfare of participants served under this waiver. In-person monitoring by the MCOs is ongoing:

- Choice and monitoring are offered every six months, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the participant.
- Choice is documented.
- The plan of care is modified to meet change in needs, eligibility, or preferences, or at least every 90 days.

In addition, the plan of care and choice are monitored by chart review, state quality review, and/or performance improvement staff as a component of waiver assurance and minimum standards. Issues found needful of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation. Related information is reported to the SED Program Manager. Collection of information involves the CMHCs sending the MCOs service plans identified in a sample. The MCOs then upload the documentation to an electronic database that the state owns and monitors. This process is new and how problems will be identified during monitoring is currently being reviewed by the state.

Service plan implementation and monitoring performance measures and related collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor/provider corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of iACT.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose service plans address all of each participants' goals
 $N = \text{Number of waiver participants whose service plans address all of each participants' goals}$
 $D = \text{Number of waiver participants whose service plans were reviewed}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95%</div>
Other	Annually	Stratified

Specify: <div>KanCare Managed Care Organizations (MCOS)</div>		Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Number and percent of waiver participants whose service plans address all of each health and safety risk factors N = Number of waiver participants whose service plans address all of each health and safety risk factors D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

Performance Measure:

Number and percent of waiver participants whose service plans address all of each of their assessed needs and capabilities as indicated in the assessment N = Number of waiver participants whose service plans address all of each of their assessed needs and capabilities as indicated in the assessment D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">95%</div>
Other Specify:	Annually	Stratified Describe Group:

KanCare MCOs		Proportionate by MCO
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

b. Sub-assurance: *The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver
N = Number of waiver participants whose service plans were developed according to the processes in the approved waiver
D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan
N = Number of waiver participants (or their representatives) who were present and involved in the development of their service plan
D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95%
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- c. **Sub-assurance:** *Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
N = Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of service plans reviewed at least every 90 days N = Number of service plans reviewed at least every 90 days D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
 $N = \text{Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan}$
 $D = \text{Number of waiver participants whose service plans were reviewed}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95%
Other Specify: <div>KanCare Managed Care Organizations</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative
 $N =$ Number of waiver participants whose record contains documentation indicating a choice of community-based services
 $D =$ Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):

Other

If 'Other' is selected, specify:

record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 10px;"></div>

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services
 $N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver services}$
 $D = \text{Number of waiver participants whose files are reviewed for the documentation}$

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers
 $N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver service providers}$
 $D = \text{Number of waiver participants whose files are reviewed for the documentation}$

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">95%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%; margin-top: 5px;">KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: 100%; margin-top: 5px;">Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program has been operationalized, staff of the three plans have been engaged with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. The role of the MCOs is collecting and reporting data regarding the waiver performance measures has evolved, with increasing responsibility as the MCOs have had greater understanding of the Kansas programs. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs</div>	Annually

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (*from Application Section 3, Components of the Waiver Request*):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (*select one*):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Kansas community mental health centers conduct level of care determinations. Decisions made by the CMHCs are subject to state fair hearing review, and notice of that right and related process is provided by the CMHC with their decision on the LOC determination/redetermination.

Kansas has contracted with three KanCare managed care organizations (MCOs) who are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member. In addition, the State will review member grievances/appeals on a daily basis to see if there are issues with getting into care, ability to get prescriptions or ability to reach a live person on the phone. The State will continue to monitor the number and frequency of these types of complaints/grievances throughout the KanCare program.

Each member is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet.

KanCare members have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 business days of receipt, and a written response to the grievance will be given to the member within 30 business days (except in cases where it is in the best interest of the member that the resolution timeframe be extended).

All KanCare members are advised the following regarding appeals and state fair hearings:

An appeal can only occur under the following circumstances:

- If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
- You will receive a Notice of Action in the mail if an Action has occurred.
- An Appeal is a request for a review of any of the above actions.
- To file an Appeal: You, your friend, your attorney, or anyone else on your behalf can file an appeal.
- An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
- An appeal must be filed within 30 calendar days after you have received a Notice of Action.
- The appeal will be resolved within 30 calendar days unless more time is needed. You will be notified of the delay, but your appeal will be resolved in 45 calendar days.

"You have other options for a quicker review of your appeal. Call your health plan for more information."

Fair Hearings

A Fair Hearing is a formal meeting where an impartial person (someone you do not know), assigned by the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.

- If you are not satisfied with the decision made on your appeal, you or your representative may ask for a fair hearing. It must be done in writing and mailed or faxed to:

Office of Administrative Hearings

1020 S. Kansas Ave.

Topeka, KS 66612-1327

Fax: 785-296-4848

- The letter or fax must be received within 30 days of the date of the appeal decision.

Members have the right to benefits while a hearing is pending, and can request such benefits as part of their fair hearing request. All three MCOs will advise members of their right to a State Fair Hearing.

Addressing specific additional elements required by CMS:

I. How individuals are informed of the Fair Hearing process during entrance to the waiver including how, when and by whom this information is provided to individuals.

For all KanCare MCOs: In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the welcome packet provided to each member. It will also be posted online at the MCOs' member web site. In addition, every notice of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance and, at any time a member can call the MCO to get additional information and assistance with the Fair

Hearing process.

II. All instances when a notice must be made to an individual of an adverse action including: 1) choice of HCBS vs. institutional services, 2) choice of provider or service, and 3) denial, reduction, suspension or termination of service.

The state requires that all MCOs define an “action” pursuant to KanCare RFP Attachment C and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event that their application (choice of HCBS vs. institutional services) is denied, MCOs issue a notice of adverse action under the following circumstances:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b); and
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

III. How notice of adverse action is made.

Amerigroup: Once the decision is made, the Medical Director notifies the Health Care Management Services department of the decision by routing the authorization request to specified queues within Amerigroup’s system of record (Facets). An Amerigroup Utilization Management nurse reviews the decision, makes any necessary updates to the authorization and routes it to the designated decision queue in Facets. The Case Specialist assigned to the queue will create the letter in Amerigroup’s document repository system (Macess) under the member’s account and send to the Amerigroup Document Control Center (DCC) for mailing to both the member and the provider.

Sunflower: Sunflower will issue notice of adverse actions in writing. The notice of action letters utilized by Sunflower will have the prior written approval of KDHE before they are used. Written notification of adverse action may also be supplemented with telephonic and/or face-to-face notifications if necessary. The notification of adverse action is provided to the member and the provider.

United: A Notice of Action is provided in writing to the member with a cc: to the provider.

IV. The entity responsible for issuing the notice

Amerigroup: Case Specialists in the Amerigroup Health Care Management Services Department are responsible for issuance of the notice (which includes the Amerigroup Medical Director’s signature). These notices are sent from the Case Specialist to Amerigroup’s Document Control Center for mailing.

Sunflower: Sunflower State Health Plan is responsible for issuing notifications to its enrolled members. Subcontracted entities who may be delegated appeal may also issue Notice of Action letters to members who are denied or received reduction of services that the delegated entity provides. All of the Sunflower’s subcontracted entities will use the previously approved notice of action and grievance/appeal process letters that Sunflower uses.

United: UnitedHealthcare Community Plan will be issuing the notices.

V. The assistance (if any) that is provided to individuals in pursuing a Fair Hearing.

Amerigroup: The Amerigroup Quality Management Department includes Member Advocates that are dedicated to tasks such as helping members file grievances, appeals and Fair Hearings. If a member calls the Amerigroup Member Services line to request assistance with a Fair Hearing, our call center provides a transfer to the Member Advocate who assists the member.

Sunflower: Sunflower’s Member Service Representative, Grievance and Appeals Coordinators and Care Managers will all be available to provide personal assistance to members needing support at any stage of the grievance process including Fair Hearing. They will provide information to members about their rights, how access the Fair Hearing process, provide assistance in completing any required documentation and provide all information relevant to the issue giving rise to the need for a Fair Hearing. In addition, Members will have access to communication assistance such as translation, TTY/TTD availability, interpreter services or alternative formats for member materials.

United: UnitedHealthcare has Member Advocates who can provide general assistance and a Plan Grievance Coordinator who is available to assist members with filing the request and who will prepare the files for submission to the State.

VI. Specify where notices of adverse action and the opportunity to request a Fair Hearing are kept.

Amerigroup: Template Notice of Adverse Action letters are housed in Amerigroup’s electronic document repository system (Macess). When individual letters are created, they are saved in the member’s individual folder within this system. All these letters include notification of the opportunity to request a Fair Hearing.

Sunflower: Sunflower will maintain records of all notices of adverse action letters issued to members, with the required Fair Hear rights and process language, in our TruCare Medical Management application and in our Customer Relations Management

(CRM) application used to track and report events in the grievance process.

United: Notice of Action letters are maintained in corporate letter archives. They are tied to the notification number in our CareOne Medical Management System. They are indexed by State, date of notice, member name, product (i.e. Medicaid) and notification number.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

- b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. However, for those situations in which the participant is not a KanCare member, this grievance/complaint system applies. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), employs the fiscal agent to operate the participants complaint and grievance system.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The MCO is open to any complaint, concern, or grievance a participant has. The MCO staff logs and tracks all complaints, concerns, or grievances. KDHE and KDADS have access to this information at any time. Both members and providers are allowed 180 days to submit a grievance to the MCO. The MCO's are contractually obligated to send members an acknowledgement letter within 5 days of receiving the grievance and an acknowledgement letter to providers within 10 days of receipt of the grievance. Each MCO identifies the type of grievance filed and works with the appropriate staff to address and resolve each grievance. The MCO's send a grievance resolution notice once the grievance has been resolved. The MCO's are contractually obligated to resolve each grievance filed within 30 days of receipt. The MCO's log and track compliance with acknowledgement letters and resolution timeframes and report that data to the State quarterly.

Once the type of grievance has been identified by each MCO's grievance coordinator, the grievance staff contact the appropriate department within each MCO to address the grievance. For a grievance concerning quality of care, each MCO's grievance coordinator routes the grievance to a member of each MCO's clinical staff. That staff person investigates the details of the grievance, identifies corrective action needed, and takes any corrective action necessary. When necessary, the MCO's grievance coordinator contacts the provider against whom the grievance was filed to ensure that clinical care standards are maintained. For a grievance concerning unsafe transportation, each MCO's grievance coordinator routes the grievance to a member of each MCO's vendor management/ transportation staff. That staff person investigates the details of the grievance, and identifies corrective action needed, including contacting the vendor to ensure safety standards are maintained. The responsible MCO staff members report the resolution of the grievances to the grievance coordinator. The same process is followed for all types of grievances (More examples: Attitude/service of staff, quality of service).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state provides for the reporting and investigation of the following major and serious incidents.

- Definitions of the types of critical events or incidents that must be reported:

Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to an adult including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship; 3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to ham an adult; 4)unreasonable use of a physical or chemical restraint, medication or isolation as punishment for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult; 5)a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult; 6)fiduciary abuse; or 7)omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness. K.S.A 39-1430(b).

Neglect: The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness. K.S.A 39-1430(c).

Exploitation: Misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person. K.S.A. 39-1430(d).

Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person's trust or benefit. K.S.A 39-1430(e).

- Identification of the individuals/entities that must report critical events and incidents:

The Kansas statute (K.S.A. 39-1431) identifies mandated reporters required to report suspected abuse neglect, and exploitation or fiduciary abuse immediately to either Kansas Department for Children and Families or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include: (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the Kansas Department for Children and Families or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection.

Reporting entities/individuals may include (but are not limited to):

All KDADS licensed providers
 Community Developmental Disability Organization (CDDO)
 Aging and Disability Resource Center (ADRC)
 Financial Management Services Providers (FMS)
 Community Mental Health Center (CMHC)
 Psychiatric Residential Treatment Facilities (PRTF)
 Substance Abuse Treatment Facilities
 Targeted Case Managers (TCM)
 Concerned community members

- The timeframes within which critical events or incidents must be reported:

All reports of abuse, neglect, and exploitation must be reported to the Kansas Department for Children and Families immediately, but no later than 24 hours upon discovery.

- The method of reporting:

Reports shall be made to the Kansas Department for Children and Families during the normal working week days and hours of operation. Reporters can call the Kansas Protection Report Center in-state toll free at 1-800-922-5330. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911.

There are currently 15 different adverse incidents being captured in the AIR system including: Abuse, Fiduciary Abuse, Neglect, Death, Law Enforcement Involvement, Restraint, Elopement, Seclusion, ER/Hospitalization, Misuse of Medications, Serious Injury, Exploitation, Natural Disaster, Suicide, Suicide Attempt and "Other" Also, the reporter has the ability to select as many adverse incidents as may apply per that particular situation. Anyone who suspects a child is experiencing any of the above types of critical incidents may report it through the DCF hotline.

AIR reports are required to be submitted to KDADS w/in 24 hours of the individual becoming aware of the adverse incident.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of plan of care/service plan development. Depending upon the individual needs of each member, additional training or information is made available and related needs are addressed in the individual's service plan. The information provided by the MCOs is consistent with the state's abuse, neglect and exploitation incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of member abuse, neglect and exploitation).

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The entity that receives reports of each type of critical event or incident: Kansas Department for Children and Families.

The entity that is responsible for evaluating reports and how reports are evaluated:

Kansas Department for Children and Families (DCF) Intake Unit is responsible for receiving reports and determining if each report is screened in or out based on current policies identified in The Kansas Economic and Employment Support Manual [KEESM] for screening reports [12210]. If the report indicates criminal activity, local law enforcement is notified immediately.

The timeframes for conducting an investigation and completing an investigation:

For children, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of a child to DCF for review and follow-up. If the report alleges that a child is not in immediate, serious, physical danger, but the report alleges critical neglect or physical/sexual abuse, DCF must respond within 72 hours. If the report alleges that a child is not in immediate, serious, physical danger and the report does not allege physical or sexual abuse or neglect, DCF must respond within 20 working days. By policy, Children and Family Services (CFS) is required to make a case finding in 25 working days from case assignment.

Reports assigned for abuse/neglect concerns shall be assigned with either a same day or 72 hour response time. The KPRC specialist shall determine the response time for abuse/neglect assignments according to the following criteria:

A. Same Day:

When there is reason to believe that a child has been seriously harmed or is in immediate serious danger, DCF shall ascertain the safety of the child and take action necessary to protect the child or cause action to be taken by emergency personnel such as law enforcement officers the same day the report is received. Examples of reports which shall be assigned for same day response:

1. Any alleged abuse or neglect of a child under one year of age.
2. Any child with current marks or bruises.
3. Life threatening situation for a child of any age.
4. Sexual abuse of a child with the alleged perpetrator in the home.
5. Child without minimal care to prevent loss of life or serious physical injury.
6. Child expresses fear of returning home.
7. Child in protective custody of law enforcement.

B. 72 Hours:

Any allegation or suspicion of abuse or neglect not assigned a same day response. DCF must ascertain the safety of the child within 72 hours excluding week-ends and state holidays of acceptance of the report.

For adults, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of an adult to DCF for review and follow-up. K.S.A. 39-1433 establishes time frames for personal visits with involved adults and due dates for findings for DCF investigations. This statute identifies the following:

1. Twenty-four (24) clock hours if the involved adult's health or welfare is in imminent danger.
2. Three (3) working days if the involved adult has been abused but is not in imminent danger.
3. Five (5) working days if the adult has been neglected or exploited and there is no imminent danger.

The entity that is responsible for conducting investigations and how investigations are conducted:

Kansas Department for Children and Families is responsible for contacting the involved child or adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

1. Interview the involved child or adult. The child's parents should also be interviewed. If the involved child or adult has a legal guardian or conservator, contact the guardian and/or conservator.
2. Assess the risk of the involved child or adult.
3. The CPS or APS social worker should attempt to obtain a written release from involved child or adult or their parent/guardian to receive/review relevant records maintained by others.

The process and timeframes for informing the participant including the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results.

2540 Notice of Department Finding:

The Notice of Department Finding for family reports is CFS 2012. The Notice of Department Finding for facility reports

is CFS 2013. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child abuse/neglect. The Notice of Department Finding also provides persons information regarding the appeal process. The following persons must receive a notice:

The parents of the child who was alleged to have been maltreated

The alleged perpetrator

Child, as applicable if the child lives separate from the family

Contractor providing services to the family if the family is receiving services from a CFS contract

The director of the facility or the child placing agency of a foster home if abuse occurred in a facility or foster home

Kansas Department of Children and Families if abuse occurred in a facility or a foster home

The Notice of Department Finding shall be mailed on the same day, or the next working day, as the case finding decision, the date on the Case Finding CFS-2011.

All case decisions/findings shall be staffed with the CPS or APS Supervisor/designee and a finding shall be made within (30) working days of receiving the report [K.S.A. 39-1433(a)(3)].

KEESM [12360] allows for joint investigations with KDADS licensed facilities per the option of the DCF Service Center and the facility. Joint investigations require a Memorandum of Agreement between the DCF Service Center and the facility which must be approved by the DCF Central Office APS Attorney. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.

There are three Program Integrity Compliance (PIC) Specialists who monitor what is called a “CSSPRC” mailbox as a way to have a view in to the Department for Children and Families (DCF) reporting system as they may correspond to any of our Adverse Incident Report (AIR) reports. Any substantiated report located in the mailbox is immediately forwarded on to the designated MCO personnel responsible for that particular beneficiary. Program Integrity staff also look to ensure if an AIR report also warrants a DCF report that those reports are being made. If not, PIC staff either follow up with the reporting party and ask them to make a DCF report, or (often times) the PIC staff will report the information to DCF themselves. The AIR system allows the reporter to reflect that a DCF report has been made. PIC staff keeps track of those reports and monitor to see the results of the DCF investigation via the mailbox. If there is a specific case PIC staff are tracking the outcome of PIC staff will contact DCF. DCF provides the determination as well as any relative information. KDADS and DCF have a plan in place for DCF to automatically upload data in to the AIR system.

The appropriate MCO is notified of every AIR report as it may pertain to any of their beneficiaries. As each AIR report arrives at KDADS it is assigned to the appropriate KDADS staff by program and respective region. KDADS staff reviews the AIR report and verify the MCO against MMIS to ensure HIPAA compliance. Once this action has been completed, the AIR system is used to notify the MCO. An email notification is provided to the appropriate MCO. If the MCO does initiate any sort of action on non-abuse, neglect, or exploitation reports, they record the result of their outreach/investigation in their local systems as well as email KDADS staff any pertinent information that should be included back in the AIR system in attempt to gain closure.

All three MCOs follow up on ALL adverse incidents regardless of type of report or who else may be involved (DCF, KDADS licensing etc). Typically, the adverse incident type would dictate which entity is the primary entity responsible for the follow up. The below chart outlines which agency is responsible for following up on which types of adverse incidents:

Adverse Incident Type Primary Entity for follow up

Abuse	DCF
Elopement	KDADS
Exploitation	DCF
Fiduciary Abuse	DCF
Law Enforcement Involvement	DCF
Natural Disaster	KDADS
Neglect	DCF
Seclusion	KDADS
Restraint	KDADS
Serious Injury	MCO
Misuse of Medications	MCO

ER/Hospitalization	MCO
Death	MCO
Suicide	MCO
Suicide Attempt	MCO
Other	KDADS

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Kansas Department for Children and Families, Division of Children's Services and Division of Adult Services is responsible for obtaining and overseeing all reports of child and adult abuse and neglect involving participants as well as all non-abuse/neglect critical incidents involving waiver participants. Each quarter, a spreadsheet of the previous quarter's participants is compared to a list of all children who have been the subject of allegations of abuse and/or neglect by the Operating Agency's Division of Children and Family Services. The list of all waiver participants is then compared to a list of all children who have been part of an investigation to determine if contact with the alleged victim was made timely and whether a investigation finding was made timely.

The critical incident reporting and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies licensed and/or funded by KDADS. It is intended to provide information to improve policies, procedures, and practices. The state oversees the incident management system by conducting investigations and quality reviews involving critical incidents. Critical incidents are reported through the state web-based system, through Department of Children and Families Reporting Network or directly to KDADS staff. Data is documented and analyzed as part of the quality assurance and improvement process. Investigations occur when required and a corrective action plan may result. The corrective action plan is designed to remediate the cause of the concern to prevent any re-occurrence.

A critical incident is reported if it occurred while the individual was participating in a Medicaid service or on any premises owned or operated by a KDADS licensed provider or facility. Each incident shall be reported using the appropriate KDADS reporting tool within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS.

Upon receipt at KDADS, email notification is sent to the appropriate program staff as determined by the provider type. The individual MCO identified on the form is notified at the same time. Reporting parameters, including timeliness and content will be determined by contractual requirements.

All reportable critical incidents shall be documented and analyzed as part of the provider's quality assurance and improvement program. Incident reports are reviewed jointly by the KDADS designated quality manager and the MCO designee to determine whether further review or investigation is needed. Reviews or investigations shall be completed following relevant KDADS policies and procedures.

For community mental health centers, if it is determined that an investigation is warranted (including those events designated in K.A.R. 30-60-55 as requiring investigation), the incident will be referred to a Peer Review Committee who is designated and are deemed to be peer review officers and/or peer review committees duly constituted by the mental health center under peer review and risk management laws, including but not limited to K.S.A. 65-4915 et. seq. and 65-4922 through 4927.

As a result of an investigation, a CMHC may be asked to submit a written corrective action plan. If such program fails to submit a corrective action plan, or if the corrective action plan does not demonstrate compliance with provider standards, the program's license may be suspended, pending satisfactory resolution of the critical incident. If the critical incident is not resolved within 12 months from the date of the initial critical incident, the program's license may be revoked.

If the perpetrator is employed by the CMHC, the Operating Agency determines whether the person is still employed by the CMHC and the steps the CMHC is taking or has taken to assure the child's safety as well as the safety of all other children receiving services at that location.

The Operating Agency shares aggregate information and findings regarding critical events or incidents with the State Medicaid Agency in both written and oral format during the monthly LTC meeting. Waiver service providers report Critical incidents within 24 hours electronically via a secure web-based reporting system, in written form, or by phone to the State.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will*

display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

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The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

HCBS SED waiver policy prohibits the following:

1. Chemical Restraint any drug administered to manage a participants behavior in a way that reduces the safety risk to the participant or others; and has the temporary effect of restricting the individuals freedom of movement; or is not standard treatment for the participant's medical or psychiatric condition.
2. Mechanical restraint - any device attached or adjacent to an individual's body that he or she cannot easily remove which restricts freedom of movement or normal access to the participants body.
3. Seclusion - involuntary confinement of a participant in an area where the participant is physically prevented from leaving as a means of controlling the participant's behavior. Seclusion is prohibited and differs from 'time out'.

The use of physical restraint as a de-escalation technique and emergency behavioral intervention is allowed only after all less restrictive interventions have been exhausted.

Regulation governing the use of physical restraint is found in K.A.R. 30-60-48:

1. Each staff member, volunteer, and contractor shall utilize only de-escalation techniques or emergency behavioral interventions which that staff member, volunteer, or contractor has been appropriately trained in or is professionally qualified to utilize.
2. No practice utilized shall be intended to humiliate, frighten, or physically harm a participant.
3. No practice that becomes necessary to implement shall continue longer than necessary to resolve the behavior at issue.
4. Physical restraint shall be used as a method of intervention only when all other methods of de-escalation have failed and only when necessary for the protection of that participant or other individuals.
5. Each instance of the utilization of a physical restraint shall be documented in the participants clinical record required by K.A.R. 30-60-46 and reviewed by supervising staff and the CMHCs risk management program required by K.A.R. 30-60-56.
6. Each instance in which the utilization of a de-escalation technique or emergency behavioral intervention results in serious injury to the participant shall be reported to the Operating Agency.

BASIS FOR USE OF RESTRAINT: Physical restraint techniques should only be used when all less restrictive methods of intervening have been exhausted, and are limited to situations in which there is serious, probable and imminent threat of bodily harm to self or others by a person with the present ability to cause such harm. Physical restraints are not allowed for the sole purpose of mediating destruction of property and must never be used as a punitive form of discipline or as a threat to control or gain compliance of a person's behavior. In all situations less restrictive alternatives including, but not limited to, positive behavior supports, constructive, non-physical de-escalation and re-structuring of the environment shall be considered prior to initiating a physical restraint, and used when feasible.

An SED waiver provider shall:

1. Administer restraints only when needed to ensure the safety of the participant and/or other individuals in the immediate environment, (including but not limited to staff members, other participants, other individuals) and only when needed to prevent the continuation or renewal of an emergency;
2. Use restraints only for the period of time necessary to accomplish its purpose and using no more force than is necessary; and
3. Prioritize prevention of harm to the participant if a restraint is administered.

DUTIES RELATED TO THE USE OF RESTRAINT:

When restraints are used, the CMHC shall ensure the following:

1. Direct care staff receive ongoing education, training, and review with a supervising QMHP and/or an assembled team of interdisciplinary professionals (that must include a supervising QMHP) to identify non-aversive techniques and strategies that aid the therapeutic process through an expansion of the participant's own internalized ability to self-regulate behavior, the progress of which is determined and evaluated by a QMHP familiar with the participant and his or her treatment history and is documented through established documentation procedures.
2. All physical restraints must be authorized by a QMHP prior to their use. Authorizations may be obtained verbally, but this authorization must be documented in the participant's clinical record by the QMHP providing authorization.
3. Restraint will only be administered by staff that have been trained to assure the physical safety of the participant.
4. A person administering the physical restraint must use only the amount of force necessary to stop dangerous or violent actions of the participant and a) no restraint is administered in such a way that the participant is prevented from breathing or communicating and b) no restraint is administered in such a way that places excess pressure on the participants chest, back, or extremities.
5. Opportunities to have the restraint removed are provided to the participant who indicates that he or she is willing to cease violent or dangerous behavior.
6. When the restraint is no longer necessary to protect the participant or ensure the safety of others, the restraint must be removed. A physical restraint shall not continue for more than 15 minutes except when essential to maintain the participants safety.

STAFF TRAINING: All CMHCs shall ensure that all SED waiver providers who may utilize physical restraints are trained according to a nationally recognized curriculum prior to providing SED waiver services. Such a program must emphasize the use of safe, non-harmful control and restraint techniques.

Training shall include:

1. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
2. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;
3. The safe use of restraint, including the ability to recognize and respond to signs of physical distress in participants who are restrained;
4. Methods to explain the use of restraint to the parents or caregivers of the participant; and
5. Documentation and notification procedures.

Individuals who are qualified by education, training and experience must provide staff training. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations. Staff must be trained and demonstrate competency before participating in an emergency safety situation. These competency evaluations must be observed and documented by the trainers. The CMHC must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training. All training programs and materials used by the CMHC must be available for review by CMS, the State Medicaid Agency, and the Operating Agency.

DOCUMENTATION REQUIREMENTS:

At intake and annually, the CMHC must:

1. Inform the participant and the parents or caregivers of the participant of the CMHCs policy regarding the use of restraint during an emergency safety situation that may occur while the participant is in the program;
2. Communicate its restraint policy that includes the types of interventions and restraints commonly used in a language that the participant and the parents or caregivers of the participant understand (including American Sign Language, if appropriate) and when necessary, the CMHC must provide interpreters or translators;
3. Obtain an acknowledgment, in writing, from the participant and the parents or caregivers of the participant that he or she has been informed of the CMHCs policy on the use of restraint during an emergency safety situation. Staff must file this acknowledgment in the participants clinical record; and
4. Provide a copy of the CMHCs policy to the participant and the parents or caregivers of the participant.

Each instance of the utilization of a physical restraint shall be documented in the participant's clinical record as required by K.A.R. 30-60-46 and reviewed by supervising staff and the CMHCs risk management program as required by K.A.R. 30-60-56, within 24 hours subsequent to a restraint being administered. Documentation of the physical restraint shall include a justification why a less restrictive intervention was not utilized or failed to keep the participant safe. All incidents of restraint will be compiled by the CMHC risk manager and reported to the Operating Agency on a quarterly basis. Each instance in which the utilization of a de-escalation technique or emergency behavioral intervention results in serious injury to the participant shall be reported by the risk manager to the Operating Agency for review within 24 hours. The Operating Agency in collaboration with the CMHC risk manager will make a determination as to referral to child protective services or law enforcement. All contacts to the Operating Agency's quality improvement field staff from the CMHC risk manager are documented in the state quality improvement quarterly reports which are aggregated and tracked to determine if trends are present. If trends are present, the Operating Agency will develop a corrective action plan with the CMHC in question seeking to prevent utilization of seclusion.

REVIEW OF THE USE OF RESTRAINT: Each CMHC shall ensure that a review process is established and conducted for each incident of restraint used. The purpose of this review shall be to ascertain that appropriate procedures are followed and to minimize future use of restraint. The review must be initiated within 72 hours of the utilization of the restraint.

The review shall include, but is not limited to:

1. Staff reviews of the incident;
2. Follow up communication with the participant and the parents or caregivers of the participant;
3. Review of the documentation to ensure use of alternative strategies; and
4. Recommendations for adjustments of procedures.

Each CMHC shall ensure that a general review process is established and conducted at least annually. The purpose of the general review process is to ascertain that procedures are appropriate.

This review shall include but is not limited to:

1. Analysis of incident reports, including but not limited to procedures used during the restraint, preventative or alternative techniques tried, documentation and follow-up training needs of staff;
2. Staff to participant ratio, especially in regard to group settings; and

3. Environmental considerations, including physical space, noise levels, access to privacy necessary for staff members to effectively utilize verbal techniques for re-establishing rapport, trust, and communication with a previously acting out participant.

Waiver service providers self-report when the unauthorized use of restraints is discovered. A report is submitted via an electronic database that is maintained by the Operating Agency's quality assurance staff. The state detects unauthorized chemical and mechanical restraints by reviewing the CMHCs risk management reports and processes, audits of the CMHCs, reports sent in by the CMHC or by individuals that reference a concern in this area.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

•The Kansas Department for Aging and Disability Services (KDADS-CSP) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue. Information and findings are reported to KDHE through quarterly/annual reports during the Long Term Care Committee Meeting.

Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of restraints. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately to the Quality Program Manager and the appropriate abuse hotline. Immediate remediation would follow the reporting. Quality field staff will be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, record review and on-site, in-person interviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restraint. KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restraints.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Data Aggregation is completed by the data analysis staff.

2. Performance Improvement Analysis Process including:

a. Performance Improvement Team including the Program Manager, Quality, data analysis staff and QMS staff reviews the data for trends and determines the necessity of changes to the tool, training or program might be necessary.

3. Performance Improvement Waiver Report provided to KDHE via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of children, regulatory standards, and statute is conducted by KDADS-CSP Field Staff (QMS) through on-going, on-site record review, observation, interviews of individuals served, guardians if applicable, and staff, review of compliance of the individual's plan of care (POC). KDADS-CSP (QMS) Field Staff are responsible for addressing all unauthorized restraint with the service provider to ensure preventative action is taken for the protection of children.

Data gathered by KDADS-CSP Field Staff during the Quality Review Process is provided quarterly to the KDADS-CSP Performance Improvement team chaired by the Quality Program Manager, for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee Chaired by the Director of KDADS-CSP, staffed by HCBS Program Managers, QA Program Manager. The Performance Improvement Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval or denial and sent to the KDHE via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval or denial from the Director of KDADS-CSP would be returned to the Performance Improvement team for corrective action or planning for implementation of improvement.

- The frequency of oversight: Continuous and ongoing.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The state agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that the state's safeguards are followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of restrictive interventions. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, on-site, in-person reviews with the participant and his/her informal supports and paid staff supports to ensure there is no inappropriate use of restrictive interventions. KDADS reviews concerns on an annual basis and as needed depending on how often concerns are reported to KDADS. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and

overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The state agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that the state's safeguards are followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of restrictive interventions. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, on-site, in-person reviews with the participant and his/her informal supports and paid staff supports to ensure there is no inappropriate use of restrictive interventions. KDADS reviews concerns on an annual basis and as needed depending on how often concerns are reported to KDADS. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Operating Agency will conduct a random sample review of the medication regimens of participants accessing waiver services through the CMHC. A focused review will be conducted on those participants who received 24 hour/round-the-clock short term respite care and professional resource family care. Any identified concerns will be referred to the PAHP Contractor's chief medical officer for further review.

Per K.A.R. 28-4-806, all Kansas Department of Children and Families (DCF) licensed facilities which deliver short term respite care and professional resource family care will receive medication administration training per DCF license requirements. DCF is responsible for the ongoing monitoring of the licensed facilities. The Community Mental Health Center is responsible for ongoing monitoring of waiver providers meeting the applicable requirements which include documentation of training and documentation of medication administration. The CMHC's documentation of the medication administration serves as the method of ongoing monitoring. The Medication Administration Record (MAR) will be completed at the time of each medication administration by the waiver provider. The scope of monitoring includes all prescription and non-prescription medications administered by waiver providers. All medication administration documentation is subject to focused review by the Operating Agency.

Requirements for administering prescription and nonprescription medication:

1. Before administering medication, each licensee shall receive training in medication administration as specified in K.A.R. 28-4-806. Each licensee shall ensure that each individual administering medication knows the purpose, side effects, and possible contraindications of each medication.

2A. For prescription medications, each licensee shall record on each participants medication record the following information: the name of the individual who administered each medication; the date and time the medication was given; any change in the participant's behavior, any response to the medication, or any adverse reaction; any change in the administration of the medication from the instructions on the label or a notation about each missed dose; and any direction from the physician to change the order as written on the label.

2B. Each medication record shall be signed by the licensee and shall be made a part of the participants medical record.

There are two ways that CMHCs monitor medication management. They monitor through clinical reviews from random charts and quality reviews from their electronic monitoring systems. The scope of the reviews can consist of prescribing patterns and drug utilization. KDADS reviews and oversight of medication regimens are conducted quarterly and as need by Medication. The state quality management specialist (QMS) monitors each licensee to ensure Medicaid providers receive training in medication administration as specified in K.A.R. 28-4-806. Each licensee shall ensure that each individual administering medication knows the purpose, side effects, and possible contraindications of each medication. Second-line monitoring is conducted by the MCOs through clinical reviews on various quality and safety metrics (i.e. a youth is on four or more psychotropic medication).

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

State oversight and follow-up regarding medication management for waiver participants is found in K.S.A. 39-7,118 which requires the State Medicaid Agency to implement a drug utilization review program with the assistance of a Medicaid drug utilization review board as provided in K.S.A. 39-7,119 and amendments thereto to assure the appropriate utilization of drugs by patients receiving medical assistance under the Medicaid program. The state is in the process of working with the Mental Health Medication Advisory Committee (MHMAC) regarding a monitoring program. The MHMAC provides recommendations to the Medicaid Drug Utilization Review (DUR) Board for the purpose of developing guidelines. The committee is composed of nine members; the Secretary of Health and Environment or the Secretary's designee, four psychiatrists, two pharmacists, one physician, and one Advanced Practice Registered Nurse (APRN). The MHMAC shall meet quarterly, or upon the request of the chair.

The drug utilization review program shall include:

- (a) Monitoring of prescription information including overutilization and underutilization of prescription-only drugs;
- (b) Making periodic reports of findings and recommendations to the Kansas Health and Environment and the United States Department of Health and Human Services regarding the activities of the board, drug utilization review programs, summary of interventions, assessments of education interventions and drug utilization review cost estimates. The state defines periodic as annually or more frequent if needed;
- (c) Providing for prospective and retrospective drug utilization review, as specified in the federal omnibus budget reconciliation act of 1990 (public law 101-508);
- (d) Monitoring provider and recipient compliance with program objectives;
- (e) Providing educational information on state program objectives, directly or by contract, to private and public sector health care providers to improve prescribing and dispensing practices;
- (f) Reviewing the increasing costs of purchasing prescription drugs and making recommendations on cost containment;
- (g) Reviewing profiles of Medicaid beneficiaries who have multiple prescriptions above a level specified by the board; and
- (h) Recommending any modifications or changes to the Medicaid prescription drug program.

The Kansas Drug Utilization Review (DUR) program provides education to physicians, mid-level practitioners, and pharmacists. This education is provided through patient profile reviews, population-based interventions, academic detailing visits, and a quarterly newsletter.

By Kansas law, the DUR Board is composed of four physicians, four pharmacists and one Advanced Registered Nurse Practitioner (ARNP) or Physician's Assistant (PA). Each appointment is for three years. The DUR Board is responsible for implementing and operating the DUR Program and making recommendations to the State Medicaid Agency regarding drug therapy issues. The DUR Board meets quarterly, the second Wednesday of the month. All meetings are held in accordance with K.S.A. 75-4319 (Kansas Open Meetings Act).

Comprehensive criteria are used to identify specific disease state or drug usage issues that affect large populations of patients. A high-impact educational intervention packet is sent to prescribing physicians alerting them of the potential issue, the patients that are affected, and the remedial action that is suggested to improve the quality of care. Since all the physician's patients with the issue are referenced in the intervention letter, a "multiplier effect" is created by impelling change in a large number of patients with a single communication.

The two types of population-based interventions utilized by the Kansas Medical Assistance Program are:

1. Drug use evaluation: Drug usage evaluation interventions target specific drugs and drug categories where pharmacotherapy is often inappropriate, cost-ineffective, potentially harmful, or of limited clinical benefit.
2. Disease management: Disease management interventions target specific disease states with significant opportunities for improving client care.

An outside contractor produces four population-based interventions on behalf of the Kansas Medical Assistance Program per year.

Though previously the DUR Board had limited impact on providing prospective drug reviews due to K.S.A 39-7, 121b which states "no requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, depression or bipolar disorder may be imposed on Medicaid recipients.

Medications that will be available under the state Medicaid plan without restriction for persons with mental illnesses shall include atypical antipsychotic medications, conventional antipsychotic medications and other medications used for the treatment of mental illness." This statute was amended to initiate a Mental Health Medication Advisory Committee to provide recommendations to the drug utilization review board for the purpose of developing guidelines for mental health drugs.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Professional resource family care and short term respite care, when provided overnight, are the two waiver services required to be provided to waiver participants in licensed family foster homes per state statute and regulation. Family foster homes are referred to as a subset of child care facilities in Kansas statute.

K.A.R. 28-4-818 outlines requirements for the storage and administration of medication in family foster homes:

(a) Storage of medication. Each licensee shall ensure that all prescription and nonprescription medication is kept in the original container at the recommended temperature in accordance with the instructions on the label and, except as specified in paragraph (e)(4), in locked storage and inaccessible to children.

(b) Nonprescription medication.

(1) When nonprescription medication is administered to any child in foster care, each caregiver shall administer the medication from the original container and according to instructions on the label.

(2) Substances including herbal supplements, folk remedies, natural medicines, and vitamin supplements other than a daily multivitamin shall be administered only with documented approval by a licensed medical practitioner.

(c) Prescription medication. When prescription medication is administered to a child in foster care, each licensee shall ensure compliance with the following requirements:

(1) Prescription medication shall be administered only to the designated child and in accordance with instructions on the label.

(2) Each prescription medication shall be kept in the original container labeled by a pharmacist with the following information: the first and last name of the child; the date the prescription was filled; the name of the licensed physician who wrote or approved the prescription; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication.

(3) The instructions on each label shall be considered the order from the licensed physician.

(4) If a daily or weekly medication container is used for a child in foster care, all of the following requirements shall be met: the medication container shall be labeled with the child's name; the medication container shall be used only for medications that are not affected by exposure to air or light and that can touch other medications without affecting the efficacy of any of the medications; the medications shall be placed in the medication container by the licensee; each dose shall be placed in the medication container according to the correct time of day; the medication container shall be kept in locked storage; the remainder of each of the child's medications shall be stored in the respective original container until the prescription is completed or discontinued; if any child in foster care is required to receive medication during a visit or during any absence from the foster home, all medication sent for the child shall be in containers that meet the requirements of paragraph (c)(2) and shall be given to the individual taking responsibility for the child; when a child in foster care moves from the family foster home, all current medications shall be in the individual original containers and shall be given to the individual taking responsibility for the child; and at no time shall any medication be in the possession of a child in foster care, except as specified in paragraph (e)(4).

(d) Requirements for administering prescription and nonprescription medication.

(1) Before administering medication, each licensee shall receive training in medication administration as specified in K.A.R. 28-4-806. Each licensee shall ensure that each individual administering medication knows the purpose, side effects, and possible contraindications of each medication.

(2)(A) For prescription medications, each caregiver shall record on each child's medication record the following information: the name of the individual who administered each medication; the date and time the medication was given; any change in the child's behavior, any response to the medication, or any adverse reaction; any change in the administration of the medication from the instructions on the label or a notation about each missed dose; and any direction from the physician to change the order as written on the label.

(2)(B) Each medication record shall be signed by the caregiver and shall be made a part of the child's medical record.

(e) Self-administration of medication.

(1) Any licensee may permit each child in foster care with a condition requiring prescription medication on a regular basis to self-administer the medication under adult supervision. Each licensee shall obtain written permission for the child to self-administer medication from the licensed physician, licensed physician's assistant, or advanced registered nurse practitioner treating the child's condition.

(2) Written permission for self-administration of medication shall be kept in the child's file at the family foster home.

(3) Self-administration of each medication shall follow the procedures specified in paragraph (b)(2).

(4) Each child in foster care who is authorized to self-administer medication shall have access to the child's medication for self-administration purposes. The child shall have immediate access to medication prescribed for a condition for which timely treatment is a life-preserving requirement. Each child with asthma, allergies, or any other life-threatening condition shall have immediate access to that child's own medication for emergency purposes. Each licensee shall ensure the safe storage of self-administered medication to prevent unauthorized access by others.

Foster parents of a Professional Resource Family Care home must successfully complete first aid training, universal precautions training and medication administration training prior to being issued a license. The Department of Children and Families is the regulatory body over these non-medical providers. Any provider that fails to meet these training requirements will receive a corrective action plan. Failure to successfully complete the corrective action plan within 30 days after the initiation of the corrective action plan may result in an enforcement action. The foster parents of a Professional Resource Family Care home are the only non-medical staff in the home.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

The critical incident reporting and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies licensed and/or funded by KDADS. It is intended to provide information to improve policies, procedures, and practices.

A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS. Medical errors must be reported as critical incidents to the state web-based critical incident reporting system. KDADS is responsible for oversight of this reporting system.

Upon receipt at KDADS, email notification is sent to the appropriate program staff as determined by the provider type. The individual MCO identified on the form is notified at the same time. Reporting parameters, including timeliness and content will be determined by contractual requirements.

All reportable critical incidents shall be documented and analyzed as part of the provider's quality assurance and improvement program. Incident reports are reviewed jointly by the KDADS designated quality manager and the MCO designee to determine whether further review or investigation is needed. Reviews or investigations shall be completed following relevant KDADS policies and procedures.

For community mental health centers, if it is determined that an investigation is warranted (including those events designated in K.A.R. 30-60-55 as requiring investigation), the incident will be referred to a Peer Review Committee who is designated and are deemed to be peer review officers and/or peer review committees duly constituted by the mental health center under peer review and risk management laws, including but not limited to K.S.A. 65-4915 et. seq. and 65-4922 through 4927.

As a result of an investigation, a CMHC may be asked to submit a written corrective action plan. If such program fails to submit a corrective action plan, or if the corrective action plan does not demonstrate compliance with provider standards, the program's license may be suspended, pending satisfactory resolution of the critical incident. If the critical incident is not resolved within 12 months from the date of the initial critical incident, the program's license may be revoked. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.

(b) Specify the types of medication errors that providers are required to *record*:

K.A.R. 28-4-818 (5) states the date and time that each medication is self-administered shall be recorded on the child's medication record. Any noted adverse reactions shall be documented. Each licensee shall review the record for accuracy and shall check the medication remaining in the container against the expected remaining doses.

According to the AIR system medication errors include: Misuse of Medications - The incorrect administration or mismanagement of medication, by someone providing a CSP service which result in or could result in serious injury or illness to a consumer.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers are responsible for reporting to the State any medication errors that are determined by contracted health professionals to have an adverse effect including, but not limited to, hospitalization or calls to poison control.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The vast majority of SED waiver participants reside in their family home where nearly all medications are administered by their parents.

All Medicaid providers, including all SED waiver providers, must immediately report all critical incidents to the State. KDADS is the state agency responsible for the on-going monitoring. Medication administration errors that result in a need for medical services are reportable critical incidents. State staff will analyze data from critical incident reporting to identify trends in medication administration errors. Providers with possible trends in medication administration errors will be required to submit a corrective action plan to the State. A critical incident report, including any possible trends, will be provided to the State Medicaid Agency at the Long-Term Care (LTC) meeting.

The state has collaborated with the MCOs to define their role and how KDADS ensures identification of problems, remediation and quality improvement activities.

The state has collaborated with the MCOs to define their role and how KDADS will ensure identification of problems, remediation and quality improvement activities.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures N = Number of unexpected deaths for which

review/investigation followed the appropriate policies and procedures as in the approved waiver D = Number of unexpected deaths

Data Source (Select one):

Other

If 'Other' is selected, specify:

record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare Managed Care Organizations; Community Mental Health Centers </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 10px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 10px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 10px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

Performance Measure:

Number and percent of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes $N = \text{Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes}$ $D = \text{Number of unexpected deaths}$

Data Source (Select one):**Other**

If 'Other' is selected, specify:

record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare Managed Care Organizations; Community Mental Health Centers </div>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation N = Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D = Number of waiver participants interviewed by QMS staff or whose records are reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations; Community Mental Health Centers</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

Performance Measure:

Number and percent of unexpected deaths for which the appropriate follow-up measures were taken N = Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D = Number of unexpected deaths

Data Source (Select one):**Other**

If 'Other' is selected, specify:

record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
Other Specify: <div>KanCare Managed Care Organizations; Community Mental Health Centers</div>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames
 $N = \text{Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver}$
 $D = \text{Number of participants' reported critical incidents}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

critical incident management system

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div>KanCare Managed Care Organizations; Community Mental Health Centers</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures N = Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D = Number of reported critical incidents

Data Source (Select one):

Other

If 'Other' is selected, specify:

critical incident management system

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (<i>check each that applies</i>):
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collection/generation (check each that applies):	(check each that applies):	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> KanCare MCOs; Community Mental Health Centers </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of unauthorized uses of restrictive interventions that were appropriately reported
 $N = \text{Number of unauthorized uses of restrictive interventions that were appropriately reported}$
 $D = \text{Number of unauthorized uses of restrictive interventions}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = 95%
Other Specify: KanCare Managed Care Organizations; Community Mental Health Centers	Annually	Stratified Describe Group: Proportionate by MCO
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: KanCare Managed Care Organizations participate in analysis of this measure's results as determined by the State Operating Agency	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

Performance Measure:

Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver. N = Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D = Number of restraint applications, seclusion or other restrictive interventions

Data Source (Select one):

Other

If 'Other' is selected, specify:

record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>KanCare Managed Care Organizations; Community Mental Health Centers</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify:	

	<input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who received physical exams in accordance with state policies
N = Number of waiver participants who received physical exams in accordance with state policies
D = Number of HCBS waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>Confidence Interval = 95%</div>
Other Specify: <div>Managed Care Organizations; Community Mental Health Centers</div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare Managed Care Organizations participate in analysis of this measure's results as determined by the State Operating Agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

KDADS-Community Service & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff. KDADS utilizes the Adverse Incident Reporting System (AIR) to track all adverse/critical incidents.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

- ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare Managed Care Organizations; Community Mental Health Centers </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement**a. System Improvements**

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS's Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful participant feedback on the HCBS program. KDADS reviews a statistically significant sample of participants for the Serious Emotional Disturbance Waiver (KS.0320) population and the other affected waiver populations under the Quality Improvement Strategy. These include the, Frail Elderly (KS.0303), Physical Disability (KS.304) waiver, Autism(KS.0476), Traumatic Brain Injury (KS.4164) and Technology Assisted (KS.4165) waiver populations. The sampling will be done for each waiver individually as will all of the data aggregation, analysis and reporting.

The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDADS Program Managers regularly communicate with Managed Care Organizations, (MCOs), the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE's Long-Term Care Committee and the interagency monitoring team and the KanCare Managed Care Organizations and contracted assessor organizations. De-identified results, to exclude any personally-identifying information, are available upon request to other interested parties. In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor's systems as well as the Managed Care Organizations' systems. On a routine basis, KDADS' Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include, but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency's critical incident management system. KDADS worked with Child Protective Services (APS), a division within the Kansas Department for Children and Families (formerly the Kansas Department of Social and Rehabilitation Services) and the Managed Care Organizations and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS' Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, Quality Review staff and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include, but are not limited to, training of the QR staff to ensure the protocols are utilized correctly, protocol revisions to capture the appropriate data and policy clarifications to MCOs to ensure adherence to policy. Additionally, any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope and severity of the issue(s).

ii. System Improvement Activities

Responsible Party (<i>check each that applies</i>):	Frequency of Monitoring and Analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> KanCare Managed Care Organizations (MCOs) </div>	Other Specify: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain participant feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with Hewlett Packard (HP) to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and HP staff to generate recommended systems changes, which are then monitored and analyzed by HP and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Operating Agency will convene an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate progress made on past remediation efforts. This will occur by reviewing the previous 372 report compared to the current 372 reports. In this review this group will determine any change in performance measures (up or down) compared to the previous 372. This group will also crosswalk previous performance measures that fell below the 87% mark which required remediation and determine the effectiveness of these efforts.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The MCOs make payments to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards.) Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1115 waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care.

In addition, these services - as part of the comprehensive KanCare managed care program - will be part of the corporate compliance/program integrity activities of each of the KanCare MCOs. That includes both monitoring and enforcement of their provider agreements with each provider member of their network and also a robust treatment, consistent with federal regulation and state law requirements, of prevention, detection, intervention, reporting, correction and remediation program related to fraud, waste, abuse or other impropriety in the delivery of Medicaid services under the KanCare program. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the KanCare program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items that touch on financial integrity and corporate compliance/program integrity. The key component of that collaboration will be through the interagency monitoring team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO include:

Coordination of Program Integrity Efforts.

The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:

- a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;*
- b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;*
- c. Report within two (2) working days to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;*
- d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;*

e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:

- (1) Oversight of the program integrity functions under this contract;*
- (2) Liaison with the State in all matters regarding program integrity;*
- (3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;*
- (4) Liaison with Kansas' MFCU;*
- (5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.*

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract $N = \text{Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract}$ $D = \text{Total number of provider claims}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

DSS/DAI encounter data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</div>	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS N=number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates

Data Source (Select one):

Other

If 'Other' is selected, specify:

Rate Setting Documentation

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The State established an interagency monitoring team to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the interagency monitoring team that engages program management, contract management and financial management staff of both KDHE and KDADS.

The MCOs are responsible for monitoring for ensuring that service plans are rendered appropriately as well as responsible for the payment to the provider.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: KanCare MCOs	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (1 of 3)**

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The resulting rates are certified to and approved by CMS.

Under managed care, HCBS provider rates are determined through contracting with the MCO while the state sets actuarial sound capitation rates that are paid to the MCO for each waiver beneficiary. The state sets the floor for the minimum rates that are required to be paid by the MCO, however. For the SED Waiver, the State's floor rates are based on prior fee for service rates and are available through KMAP. Capitation rates are based on actuarial analysis of historical data for all SED program services. These rates are based on historical claims and carried forward for KanCare Managed Care.

All waiver services are included in the capitation rates.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for services are submitted to the MCOs directly from waiver provider agencies delivering SED waiver services. All claims are either submitted through the MMIS portal, the State's front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. Capitated payments in arrears are made only when the participant was eligible for the Medicaid waiver program during the month.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it

is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECS, the State's eligibility system.

Post payment billings are conducted by the MCOs.

The State's Quality Management Staff (QMS) conducts quarterly and annual reviews, which includes reviewing case file documentation to see if choice was provided and if the participant signed the Choice document. Additionally, participant interviews have been completed, inquiring if they were provided choice. During the interview of the participant QMS identifies if a provider choice form was presented to the family, asks how the provider choice was decided and if services were rendered according to those identified on the participant's POC.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

The MMIS Managed Care system assigns beneficiaries to one of the three KanCare Plans. Each assignment generates an assignment record, which is shared with the plans via an electronic record. At the end of each month, the MMIS Managed Care System creates a capitation payment, paid in arrears, for each beneficiary who was assigned to one of the plans. Each payment is associated to a rate cell. The rate cells, defined by KDHE as part of the actuarial rate development process which is certified to and approved by CMS, each have a specific dollar amount established by actuarial data for a specific cohort and an effective time period for the rate.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs. The MCOs reimburse on claims provided. Providers are paid by the MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

--

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.
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Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

--

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures are directly expended by KDADS. Medicaid payments are processed by the State's fiscal agent through the Medicaid Management Information System using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. KDHE – Division of Health Care Finance draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on capitation payments in the KanCare program.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

Not Applicable. *There are no local government level sources of funds utilized as the non-federal share.*

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Per Appendix I-2-a., Capitation rates are based on actuarial analysis of historical data for all SED program services. These rates are based on historical claims and carried forward for KanCare Managed Care. The MCO's are responsible for trending costs and demonstrating financial experience going forward. Based on the data collected, the MCO may request the State's review for cost adjustments.

Payments to providers for room and board are not processed through the Medicaid system and are therefore not included in any Medicaid cost reports.

Consistent with statute, the State contracts for a biennial rate study every other year. Although the vendor collects financial information regarding room and board, the information is excluded from any vendor recommendations regarding reimbursement rates.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the

waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	1131.28	14126.71	15257.99	34500.00	15500.00	50000.00	34742.01
2	1131.28	14126.71	15257.99	34500.00	15500.00	50000.00	34742.01
3	1131.28	14126.71	15257.99	34500.00	15500.00	50000.00	34742.01
4	1131.28	14126.71	15257.99	34500.00	15500.00	50000.00	34742.01
5	1131.28	14126.71	15257.99	34500.00	15500.00	50000.00	34742.01

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	4600		4600
Year 2	4600		4600
Year 3	4600		4600
Year 4	4600		4600
Year 5	4600		4600

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average Length of Stay was calculated by using the total days of waiver coverage for Federal Fiscal Year 2015 (10/1/2014 to 09/30/2015) : 1,117,915 divided by the unduplicated number of youth receiving SED Waiver services during the same time period: 4,252 or 262.9 days average length of stay.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D was estimated by utilizing data from the Kansas MMIS system and reflects MCO payments to the providers for Federal Fiscal Year 2015, 10/01/2014 to 09/30/2015. This will only be a projection of MCO encounters and not be reflective of the State's Capitation payments made to the MCO.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was projected by obtaining the average SED waiver capitation cost for Federal Fiscal Year 2015 (10/01/2014 to 09/30/2015) minus the MCO encounter payments made to providers during Federal Fiscal year (10/01/2014 to 09/30/2015).

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was estimated and reflects the average institutional cost and utilization for children in the replacement facilities for the former state hospitals for children for the Federal Fiscal Year 2015 (10/1/2014 to 09/30/2015).

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was estimated and reflects the average acute care cost and utilization for children in replacement facilities for the former state hospitals for children for the Federal Fiscal Year 2015 (10/1/2014 to 09/30/2015).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Attendant Care	
Independent Living/Skills Building	
Short-Term Respite Care	
Parent Support and Training	
Professional Resource Family Care	
Wraparound Facilitation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							1865996.82
Attendant Care		15 minutes	2115	146.80	6.01	1865996.82	
Independent Living/Skills Building Total:							68530.64
Independent Living/Skills Building		1 hour	266	7.80	33.03	68530.64	
Short-Term Respite Care Total:							1840393.76
GRAND TOTAL:							5203904.29
Total: Services included in capitation:							5203904.29
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							1131.28
Services included in capitation:							1131.28
Services not included in capitation:							
Average Length of Stay on the Waiver:							263

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Short-Term Respite Care		15 minutes	1221	252.90	5.96	1840393.76	
Parent Support and Training Total:							640680.64
Individual		15 minutes	2620	27.00	8.88	628171.20	
Group		15 minutes	151	27.80	2.98	12509.44	
Professional Resource Family Care Total:							50317.72
Professional Resource Family Care		1 day	18	22.10	126.49	50317.72	
Wraparound Facilitation Total:							737984.70
Wraparound Facilitation		15 minutes	3771	10.00	19.57	737984.70	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							5203904.29 5203904.29 4600 1131.28 1131.28 263

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							1865996.82
Attendant Care		15 minutes	2115	146.80	6.01	1865996.82	
Independent Living/Skills Building Total:							68530.64
Independent Living/Skills Building		1 hour	266	7.80	33.03	68530.64	
Short-Term Respite Care Total:							1840393.76
Short-Term Respite Care		15 minutes	1221	252.90	5.96	1840393.76	
Parent Support and Training Total:							640680.64
Individual		15 minutes	2620	27.00	8.88	628171.20	
Group		15 minutes	151	27.80	2.98	12509.44	
Professional Resource Family Care Total:							50317.72
Professional Resource Family Care		1 day	18	22.10	126.49	50317.72	
Wraparound Facilitation Total:							737984.70
Wraparound Facilitation		15 minutes	3771	10.00	19.57	737984.70	
GRAND TOTAL:							5203904.29
Total: Services included in capitation:							5203904.29
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							1131.28
Services included in capitation:							1131.28
Services not included in capitation:							
Average Length of Stay on the Waiver:							263

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							1865996.82
Attendant Care		15 minutes	2115	146.80	6.01	1865996.82	
Independent Living/Skills Building Total:							68530.64
Independent Living/Skills Building		1 hour	266	7.80	33.03	68530.64	
Short-Term Respite Care Total:							1840393.76
Short-Term Respite Care		15 minutes	1221	252.90	5.96	1840393.76	
Parent Support and Training Total:							640680.64
Individual		15 minutes	2620	27.00	8.88	628171.20	
Group		15 minutes	151	27.80	2.98	12509.44	
Professional Resource Family Care Total:							50317.72
Professional Resource Family Care		1 day	18	22.10	126.49	50317.72	
Wraparound Facilitation Total:							737984.70
Wraparound Facilitation		15 minutes	3771	10.00	19.57	737984.70	
GRAND TOTAL:							5203904.29
Total: Services included in capitation:							5203904.29
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							1131.28
Services included in capitation:							1131.28
Services not included in capitation:							
Average Length of Stay on the Waiver:							263

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							1865996.82
Attendant Care		15 minutes	2115	146.80	6.01	1865996.82	
Independent Living/Skills Building Total:							68530.64
Independent Living/Skills Building		1 hour	266	7.80	33.03	68530.64	
Short-Term Respite Care Total:							1840393.76
Short-Term Respite Care		15 minutes	1221	252.90	5.96	1840393.76	
Parent Support and Training Total:							640680.64
Individual		15 minutes	2620	27.00	8.88	628171.20	
Group		15 minutes	151	27.80	2.98	12509.44	
Professional Resource Family Care Total:							50317.72
Professional Resource Family Care		1 day	18	22.10	126.49	50317.72	
Wraparound Facilitation Total:							737984.70
Wraparound Facilitation		15 minutes	3771	10.00	19.57	737984.70	
GRAND TOTAL:							5203904.29
Total: Services included in capitation:							5203904.29
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							1131.28
Services included in capitation:							1131.28
Services not included in capitation:							
Average Length of Stay on the Waiver:							263

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (9 of 9)****d. Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							1865996.82
Attendant Care		15 minutes	2115	146.80	6.01	1865996.82	
Independent Living/Skills Building Total:							68530.64
Independent Living/Skills Building		1 hour	266	7.80	33.03	68530.64	
Short-Term Respite Care Total:							1840393.76
Short-Term Respite Care		15 minutes	1221	252.90	5.96	1840393.76	
Parent Support and Training Total:							640680.64
Individual		15 minutes	2620	27.00	8.88	628171.20	
Group		15 minutes	151	27.80	2.98	12509.44	
Professional Resource Family Care Total:							50317.72
Professional Resource Family Care		1 day	18	22.10	126.49	50317.72	
Wraparound Facilitation Total:							737984.70
Wraparound Facilitation		15 minutes	3771	10.00	19.57	737984.70	
GRAND TOTAL:							5203904.29
Total: Services included in capitation:							5203904.29
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							1131.28
Services included in capitation:							1131.28
Services not included in capitation:							
Average Length of Stay on the Waiver:							263